Vol. X OCTOBER, 1962 No. 1

THE BULLETIN

School of Medicine
University of North Carolina

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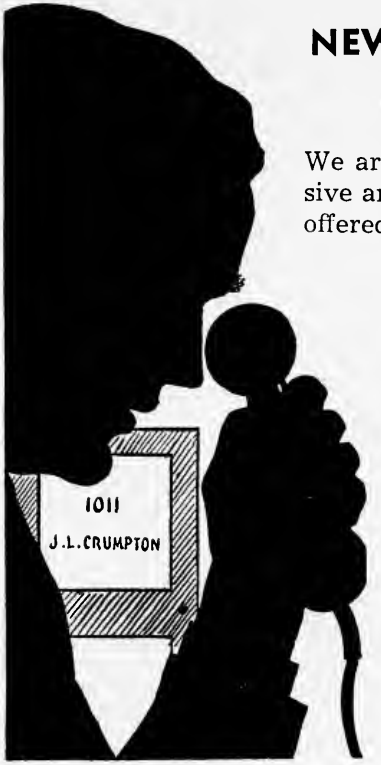

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A WORD OF THANKS

Dr. Ernest Craige is an outstanding citizen of the University of North Carolina School of Medicine, and is well-known throughout the state and beyond as a clinician, teacher, and investigator of high character. His personal attributes match his professional capabilities, and he is clearly one of our most respected and popular people. Among the many tasks on behalf of the school which he has encumbered during the past decade, has been the editorial direction of the Bulletin. Its steady growth as a friendly and informative communication between the school, its student body, house staff, and faculty and its alumni and friends has been due in great part to the efforts of Dr. Craige and the members of his committees since 1953. The present editorial committee acknowledges with gratitude Dr. Craige's many contributions to the Bulletin during his years as its Editor.

THE BULLETIN

of the School of Medicine
of the University of North Carolina

Published in cooperation with the Whitehead Medical Society
and the Medical Foundation of North Carolina, Inc.

Vol. X | October, 1962 | No. 1

IN THIS ISSUE

THE NEW COVER *was designed by Mrs. Adele Speigler of the Department of Medical Illustrations, UNC School of Medicine*

Editorial Committee

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Published four times a year — October, December, February and April — Entered as third-class matter at the Post Office at Chapel Hill, N. C.

The University Medical Center 1952-1962

by W. Reece Berryhill, *M.D., '25, Dean*

In September, the second decade of operation of the expanded School of Medicine and the North Carolina Memorial Hospital—the University Medical Center—began. The achievements of the first ten years have been significant—in many areas, exciting. There has been continued growth in quality, in quantity and progress in education and training at all levels relating to medicine, in research, and in patient care. These developments and contributions are making an impact upon the quality of medicine in the State and have gained national recognition for the University in the field of medicine.

The problems of the earlier years—those inherent in the expansion or development of all new four year medical schools—are now largely behind us. All in all, these have been fewer, within the Medical Center itself, than in most of the medical schools which have expanded or have been developed entirely from "scratch" in this and earlier decades.

The understanding and support of the University administration, trustees, alumni, friends, faculty, students, house staff, leaders in the General Assembly, and of the State's Chief Executive during these years have been of very great value, and to all of these, we are grateful.

The following seem to me to be contributions and developments of which the alumni and friends and indeed the entire State can be proud and which justify optimism and hope for the next decade.

I. EDUCATION

(A) *Undergraduate Medical Students*

Beginning with those admitted in the first graduating class of 1954 and including the current freshman class, 871 students have been admitted. Of these, 96 per cent were residents of North Carolina and have come from 87 counties. This represents almost 50 per cent of all State residents who have entered all medical schools in the United States during this period and more than 50 per cent of those who have attended medical schools in North Carolina.

Five hundred and forty-one have graduated and of those who have completed both their graduate medical training in hospitals and military obligations, approximately 90 per cent have entered practice in North Carolina in 63 counties and are located from Burnsville in the West to Sea Level on the Coast. Approximately 31 per cent of these are in Family Practice. There is still a large backlog of graduates in residency training or in military service.

(B) *Graduate Education*

Several of the basic science departments had been approved by the University Graduate School for the Masters and Ph.D. Degrees for many years before the School's expansion, but in the past ten years, both the number and the quality of graduate students studying for advanced degrees in the Departments of Biological Chemistry, Bacteriology, Physiology, Pathology, and just recently in Genetics, have increased and improved. For this session they number 55.

Graduate education (residency programs) has been developed and approved by the appropriate Boards in all clinical specialties. In addition, during this period, the hospital has provided an internship and residency designed especially for those interested in Family Practice. During the last few years, here as elsewhere, there has been an increasing number of fellows and trainees in the clinical and basic science departments made possible by funds from the National Institutes of Health. This year this latter group numbers 40.

In the development of the residency programs, the resources of several affiliated hospitals have been utilized. For example, in both the surgical and psychiatry residences, experience in the State mental hospitals of Umstead and Dix Hill are included. There are joint residency programs in (1) opthalmology involving the North Carolina Memorial Hospital, the McPherson Hospital in Durham, and the State mental hospitals; (2) in urology, Watts Hospital—North Carolina Memorial; and (3) in obstetrics, North Carolina Memorial—Southeastern General and the Wake County Memorial. The joint residency in psychiatry involving our own service and the State mental hospitals is generally well known and with the continued efforts of the institutions involved has played an important part in the improved standards of patient care currently prevailing in our mental institutions.

(C) *Continuation Education*

There has been a considerable expansion and diversification of the long established continuation education program for practicing physicians, including within the past year the initiation of the weekly two-way radio programs involving the staff of some ten community hospitals with their county medical societies. The registration of physicians in these postgraduate courses for the decade, since 1951, totals over 5,000. Finally, opportunities have been provided for undergraduate degrees in Medical Technology and in Physical Therapy, as well as a certificate program in X-Ray Technology.

II. THE FACULTY

The University has been fortunate over this period in attracting an able faculty in all departments, and although there have been some regrettable losses, it is really amazing and, at the same time, reassuring that so very many of the ablest remain and continue their efforts to build a better

School of Medicine. More and more their accomplishments are being recognized throughout the country and even internationally. In numbers, the full-time faculty has grown from 92 in 1952 to 189 in 1962, while the very valuable part-time group has increased from 55 in 1952 to 163 in 1962.

The following are cited as at least a few indications of the quality of the faculty. During this period, eight faculty members have been selected as Markle Scholars in the Medical Sciences:

Dr. John B. Graham—Professor of Pathology
Dr. George D. Penick—Associate Professor of Pathology
Dr. Isaac M. Taylor—Associate Professor of Medicine
Dr. Judson J. Van Wyk—Professor of Pediatrics
Dr. Franklin Williams—Associate Professor of Medicine and Preventive Medicine
Dr. Walter Hollander, Jr.—Associate Professor of Medicine and Director, Clinical Research Unit
Dr. Robert Zeppa—Assistant Professor of Surgery and Associate Director, Clinical Research Unit
Dr. William D. Huffines—Assistant Professor of Pathology

The following have been awarded Research Career Development Awards, USPHS (Formerly USPHS Research Fellows):

Dr. Isaac M. Taylor—Associate Professor of Medicine
Dr. Robert D. Langdell—Associate Professor of Pathology
Dr. Edward Glassman—Assistant Professor of Biochemistry
Dr. John K. Spitznagel—Associate Professor of Bacteriology and Assistant Professor of Medicine
Dr. Charles L. Johnston—Assistant Professor of Physiology
Dr. Robert H. Wagner—Associate Professor of Pathology and Biochemistry
Dr. Martin H. Keeler—Assistant Professor of Psychiatry
Dr. Billy Baggett—Associate Professor of Pharmacology and Biochemistry
Dr. Ira Fowler—Associate Professor of Anatomy
Dr. Arthur J. Prange, Jr.—Assistant Professor of Psychiatry

Two members of the faculty have been selected for the USPHS Career Research Awards:

Dr. Judson J. Van Wyk—Professor of Pediatrics
Dr. Morris A. Lipton—Associate Professor of Psychiatry

Dr. Carl W. Gottschalk has been awarded an American Heart Association Career Investigatorship, which, by its terms, is equivalent to an endowed professorship. There have been only eleven such awards to date in the United States and Canada.

With these and many others of high ability, the potential of the School and its future would appear bright indeed and its place secure, *provided* opportunity to continue to work under reasonably adequate conditions can be assured. At the moment, the adequate conditions very largely mean *SPACE!*

III. THE HOSPITAL SERVICES—PATIENT CARE

Since September 1952 when the North Carolina Memorial Hospital opened with 76 beds activated, there have been added Gravely Sanatorium with 100 beds for care and study of tuberculosis and chronic chest diseases and the psychiatric pavilion with 54 beds for inpatients and an out patient department. One floor of this building now houses temporarily the 12-bed general Clinical Research Unit.

Special mention should be made of the important role played by the Gravely Sanatorium in the Medical Center. While administratively separate, it is functionally an internal part of the teaching—for undergraduates and house officers—and patient care responsibility of the School of Medicine and especially of the Departments of Medicine and Surgery.

The number of activated beds in Memorial Hospital has increased from 76 to 385—this does not include the 100 in Gravely. The annual occupancy rate is over 80 per cent and for the greater portion of the year, near 90 per cent. The current addition of a ten-bed isolation ward (7th floor porch enclosure) in pediatrics and the full activation of the special care ward—dependent on adequate nursing coverage—will bring the bed capacity to 413 or all the beds which can be provided until a major expansion has been completed.

From the standpoint of both medical care and teaching, the ambulatory clinic is assuming increasing and major importance. At the end of the first year of operation, there were approximately 25,000 patient visits. Ten years later, the number had increased to 105,000 visits. Here again, inadequate space causes delays in appointments for patients and otherwise handicaps the value and effectiveness of this service. This is the reason that an enlarged new ambulatory clinic for staff and private patients has been determined as the first priority in the proposed new addition to the hospital.

In the developments in the area of patient care, special mention should be made of the initial development of the Acute Care Unit, its well proven value to patients, and its subsequent extension and broadening to a Special Care Ward to include special facilities for the treatment of severely burned patients, paraplegics, and other diseases or conditions requiring care that can best be given in such a facility. This represents one important step in implementing the important concept of graded patient care which the faculty and the administration of the Hospital and School have determined to effect throughout the hospital as soon as adequate space can be provided.

There has been a continuing interest in various aspects of rehabilitation. Valuable assistance in implementing these concepts in both teaching and patient care has been made by financial support from the National Foundation and the Office of Vocational Rehabilitation. Mention should be made of the work of Dr. Peacock in plastic surgery, especially of the hands and in speech therapy with children who have had cleft palate operations, the development of the Hearing and Speech Center under the direction of Dr. Newton Fischer, and the broad medical interests of Dr. Donald D. Weir.

Perhaps one of the most important moves of this period was to combine—functionally and administratively—the Hospital and Medical School, effected in 1956, so that the Hospital became a department or a division within the Medical School.

IV. RESEARCH

The contributions of the faculty in investigation in many and varied fields of the basic medical sciences and in the clinical departments are widely known and respected and have done much to establish and further the reputation of the University Medical Center. Although in the past five to six years the availability of funds from the National Institutes of Health for investigation and special training has increased enormously, at the same time, it is significant that for the year 1952-53 the total funds from sources outside the State appropriated budget for the support of research and special teaching and training projects totalled $380,000, while for the year 1961-62 such funds were of the order of $3,330,000.

Another development of very real significance which provides additional evidence of the high quality of the faculty is the award during the past two years of funds in the amount of approximately $3,500,000 over a seven year period to support (a) a general clinical research unit for the careful study of various disease processes in humans and (b) a categorical clinical research unit for the study of hemorrhage and thrombosis in humans.

V. FINANCES

The financial support for a university medical center, whether in a state or privately controlled university, must come from many and varied sources and presents many complex problems. For years prior to 1947 and even later, it was argued by many that the State of North Carolina not only didn't need an expanded University Medical School but that it could not and would not provide adequate financial support. Experience thus far has shown that perhaps the State could not provide adequate financial support in toto for the adequate and complete operation of all the activities of this or comparable medical institutions at this period in the explosive developments in medicine. At the same time, with all its increasing obligations, the State of North Carolina has been reasonably generous in the support it has provided for the Medical School and the hospital services although such funds provide support for only a portion of the total needs.

In 1952-53, the State appropriation for the Medical School was $646,642, in 1962-63, $1,480,091; for the North Carolina Memorial Hospital in 1952-53 the State appropriation was $1,067,176 (prior to opening the psychiatric pavilion), and for 1962-63, the State appropriation for the entire Hospital, including the psychiatric service, which has always enjoyed a higher appropriation than the remainder of the Medical Center is $2,448,000.

This report—already too long—is a summary of some of the developments and accomplishments during the first decade of the expanded School. Obviously, all of us can rightly have a feeling of pride and some degree of

satisfaction, as well as great hope for the future. At the same time, the medical faculty is keenly aware of the gaps which must be filled and the shortcomings that prevail.

There is a healthy dissatisfaction which continually motivates us all toward higher goals for the second decade. We are convinced that the future of the School is in large measure dependent upon how quickly more adequate physical facilities can be provided. In the attainment of these, you, as alumni, have a very key role to play, and we are confident you will do your utmost as the alumni, many of them your seniors, did in the period 1945-1952.

The Very First Patient

By THOMAS B. BARNETT, M.D.

While the first patient admitted to the North Carolina Memorial Hospital, the patient bearing Unit Number 1, is well-known as a result of considerable publicity at the time, the very first patient officially seen after opening the doors of this institution on September 2, 1952, was an out-patient seen in the General Clinic quite early on the morning of that first day.

Having been much involved in the planning for the opening of the hospital and particularly for the beginning of activities in the Out-Patient Department General Clinic, I was here quite early on the morning of September 2, 1952. The very first patient was here early on that morning for a somewhat different reason. She was an 18 year old Negro female, the mother of 2 children, aged 2 years and 1 year respectively. She was expecting her third almost any day. Since the plan had been to open the North Carolina Memorial Hospital on or about July 1, 1952, this patient had not consulted a physician during this pregnancy but had planned to come here as soon as the hospital opened. Because of unavoidable delays, the opening of the hospital came distressingly close to her expected date of confinement. As I have said, she was here quite early in the morning for good reason.

The patient was examined and a diagnostic impression of pregnancy, uterine, near term, was made. An obstetrician was called into consultation and the diagnosis was confirmed by him. Within a few days, the patient appeared in the Emergency Room in active labor, but since the section of our new hospital designated for obstetrical patients and the associated nursery were not ready for occupation, it was necessary to refer the very first patient to a near-by institution where she was delivered of a normal, healthy infant. This patient has continued to be followed in our clinic and was last seen May 21, 1962.

This statement is being published as a matter of record and to illustrate how it was in the early days when the General Clinic was really a general clinic.

Dr. Barnett is Associate Professor of Medicine, U.N.C. School of Medicine.

Reflections on Problems of A Medical Center

by Chester Keefer, M.D.

The following article concerns current problems of medical education, practice and research. It reflects some of the views of Dr. Chester Keefer, who delivered these remarks to members of the Departments of Medicine and Pediatrics of the University of North Carolina School of Medicine during an interdepartmental conference held at Sedgefield, North Carolina, February, 1962. Dr. Keefer, formerly Wade Professor of Medicine, Boston University School of Medicine and Physician-in-Chief, Massachusetts Memorial Hospitals, is now University Professor, Boston University.

Training programs are of several sorts. Resident training programs are usually designed to train generalists in medicine or pediatrics. Research training programs are designed for the training of men who plan to follow an academic career as teacher-investigators, or as investigators without teaching responsibilities. In general, it can be said that these programs are quite different in content and emphasis, but in the clinical services they usually start after an internship.

It should be recalled that resident and research training programs in the United States have multiplied at an astonishing rate since World War II.

Also, resident training programs were designed, for the most part, during the early part of this century for the training of teacher-consultants, and not for teacher-investigators. The internship was designed for the better preparation of the practitioner, the safe practitioner, but not for the specialist.

Gradually, the resident training programs were changed to train teacher-investigators, who would devote their full time to this activity. The young man would spend half of his time in the care of general medical patients, and the other half working with an older man, under supervision and as a partner, doing clinical investigation. This was the system and it developed at a rapid pace. The type of training changed rapidly and was further divided into resident training and research training. This was due, in part, to the establishment of certifying boards, accrediting agencies for hospitals and training programs. It was also conditioned by the growth of specialization, the increase in the number of special services provided for patients, and the growth of resources to support such programs of research-fellowships.

Most resident training programs today are designed to train practitioners. Some will be part-time teachers in medical schools, others will not. They are

educational, training and service programs combined. In design, they aim to provide postgraduate training that makes a good physician out of an M.D.

Clinical research training programs, in contrast to resident training programs, are relatively new and the line separating them may be rather thin. The division of the two is often artificial and has an economic determinant.

Fellowship-traineeships which carried with them an honorarium were very few indeed prior to 1946. There were a few fellowships in medicine in our large universities. The foundations offered fellowships either directly or through institutions or agencies such as the National Research Council but, by and large, they were few. About the only way that a young man could obtain training as a clinical investigator was to win a spot in a resident training program as they existed in a few university hospitals or in institutes like the Rockefeller Hospital.

The situation today is in a state of flux and it has been changing rapidly for many reasons. But, we must not overlook the central objective of all training programs. This is: to train better doctors, whether the primary objective of the doctor with respect to function is the practice of medicine, or to become a teacher-investigator or just an investigator. It is our job as academicians to provide opportunities for young men and women to develop along the paths of their greatest skill and aptitude. Programs should be developed that have freedom and flexibility.

If we agree that our duty as university people is to produce more and better doctors, more and better teachers and investigators, then it is both our responsibility and duty to provide the best opportunities for self-development in the care of patients and in advancing knowledge.

The Training of the System Specialist

A system specialist is a person who concentrates his attention, his research or investigation, in a narrow rather than a broad area, although the system itself may be very broad indeed. Let me illustrate what I mean. Professor Michelson, Nobel Prize Laureate for his work in the physics of light, told me one time that this had been his life-long interest and that he did not know what other physicists in his department were working on except in a general way. He used his knowledge of light, gained by experiment, to study its speed as well as measure such phenomena as land tides in contrast to sea tides. This is the extreme of system specialists in physics.

There are some men who have a passion and an intense desire to learn as much as they can about a system or a region, such as the heart and blood vessels, allergy, etc. This has led to the creation of specialty boards, sometimes called sub-specialty boards.

The trend today is that some men want to qualify and be identified with a specialty or a system specialty and they want to concentrate upon a specific subject early in their medical careers. For those who choose this path of training, opportunities and encouragement should be stimulated. The training of such a person should encompass a period of generalization, perhaps not more than a year or two after graduation from medical school, and then be followed by specific training. This is best carried out within specialized sections of research training.

Here, opportunities should be available for men to study the basic sciences of mathematics, physics, biology, etc., as a part of research training and I might add, the history of science as well as science in history. The latter adds to our understanding and certainly helps the system specialist in his work and assists him in becoming not only a skilled technician but a scholar.

Interdepartmental Relations

The next topic I propose to discuss is interdepartmental relations. This subject applies not only to relations between departments of pediatrics and medicine but to all departments within a university medical school or center. In the recent past, I have made some general observations upon the importance of the practice of interdepartmental relations (interdisciplinary) and professional collaboration in medicine is both necessary and essential for several reasons. It is necessary for the advancement of science, the improvement of health, and the education and training of the doctor. By professional collaboration, I mean a closer intellectual contact among the members of departments and specialties and the substitution of group objectives, voluntarily accepted, for the individual objectives of the members.

As specialism increases, the need for improved professional collaboration between departments becomes necessary because the exchange of ideas and better communication between groups aids in the definition of problems, and opens up and stimulates new paths of investigation. The need for further improvement of interdepartmental relations in our medical centers is important for both doctors and patients. It accelerates the advancement of knowledge and its application. Let me give you a striking example of professional collaboration between specialists.

The Alfred Hess-Adolph Windhaus Story

When dermal tissues are radiated with ultraviolet rays *in vitro,* they have antirachitic power. Alfred Hess and Weinstock proved this by feeding human

or calf skin to rats on a rachitogenic diet; while non-radiated skin had little or no healing effect. Thus, sunlight activates a provitamin in the skin. Hess was tormented by this observation and his own chemistry was inadequate to solve the problem. He invoked in vain the aid of several American chemists. He knew that the skin contained ergosterol and cholesterol but he was unable to determine what substance developed following exposure to ultraviolet light.

Finally, he communicated his problem, his findings, and his hypotheses, to Professor Adolph Windhaus, the great biochemist at Gottingen, Germany, the world's expert steroid chemist of that time. It is reported he said to Windhaus, "What substance develops following ultraviolet light exposure of ergosterol or cholesterol?" Windhaus said 7-dihydrocholesterol or "viosterol." He went ahead and solved the problem and was awarded the Nobel Prize for his work on cholesterol and vitamin D. As a fitting appreciation of the part which Hess had played, he divided the honorarium with Hess, who used it, as he had long been using his own private resources, in the further prosecution of his studies.

Here, then, is an example of true collaborative research, by foremost investigators working together and searching for new facts which have practical importance in safeguarding or improving health.

The means of developing and improving interdepartmental collaboration always presents problems and calls for thorough self-examination on a continuing basis because it is a dynamic process and calls for maintaining strong interpersonal relationships. We need to recognize the advantages and work hard to overcome the difficulties.

A fair question is, how can interdepartmental relationships be improved? First of all, I submit that there must be appreciation of the need and the idea, and the joining together of groups as true partners for progress. This requires acceptance of the doctrine of equality of respect among all participating groups, which is one of the basic premises of any such relationship.

Second, an element of potential success is the development of what might be called, in the common jargon of the day, a positive program, that is, a plan based upon objectives and goals and an expression of the results you hope to achieve, agreed to by the participants, based upon local needs and available facilities and evolved by the staff or personnel of the combined departments. It requires planning and organization for the flow of work, and adequate financing with proportionate contributions of resources.

Third, in the development of any program, one must build and lead from strength. One must capitalize upon the skills, imagination and intellectual experience of the members of the group and their voluntary acceptance of a group objective.

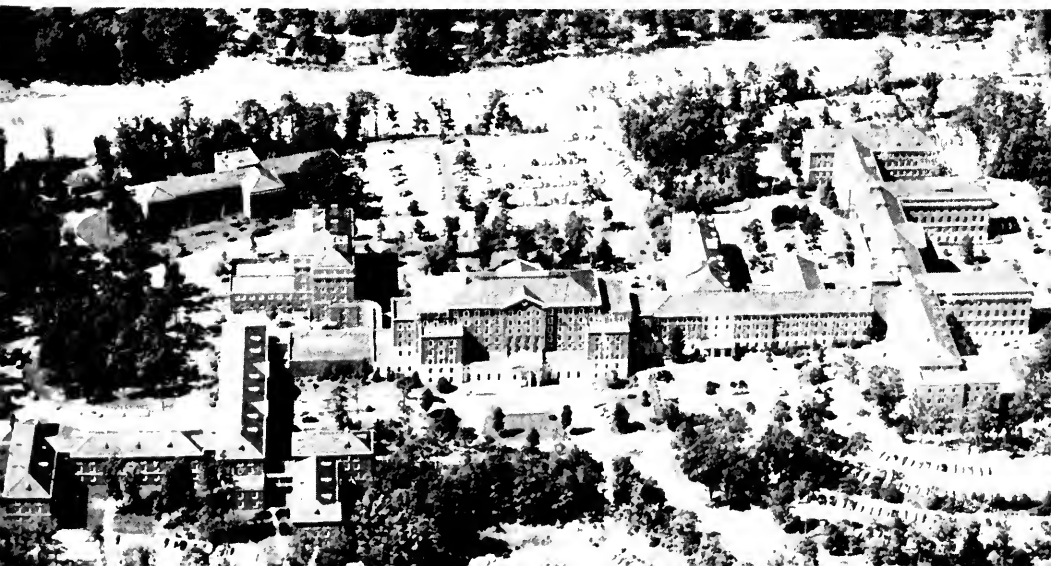
Fourth, the program should avoid conformity to a rigid and regimented pattern as determined by an outside approving authority. It should allow for freedom and flexibility for maximum development.

In short, then, improved interdepartmental relationships with respect to teaching, research and patient care in our medical centers are essential if we are to advance knowledge, transmit it and apply it for the benefit of the patient.

Now, it must be recognized that some scientists, like Einstein, work best as individuals and do not work well in tandem. Insofar as such individuals are concerned, their talents must be respected but insofar as professional collaboration is concerned, they can be forgotten because there are too few of them, and

YESTERDAY AND TODAY

Pictured here are scenes photographed more than ten years ago at the beginning and during construction of the UNC School of Medicine and Memorial Hospital. The bottom right photo shows the center as it appears today. Within a few months, a wooded area containing two small buildings (the infirmary and old medical school) was transformed into the complex structure shown as it now exists. Will changes during the next ten years be as great?



they do their best work and make their greatest contributions in an environment such as an institute for advanced study where they have no duties but only opportunities of individual achievement.

The interdependence among various medical disciplines is great and is increasing because of the accumulation and advancement of knowledge and the growth of specialization.

The need to improve communications between departments by working together with a set of goals should be a major objective.

I turn attention now to the third topic; namely, the merits and defects of the present divisions of family medical care by general practitioners, pediatricians and internists.

Patterns of family medical care and their quality vary from one community to another, depending upon many factors—the number of physicians and their age, background, education and training, the accessibility and availability of health resources (hospitals, public health stations or centers, laboratory facilities, nurses and social agencies), the socio-economic status of the community (per capita income) and finally, the kind of medical care the family will select, accept and pay for. This is related to public attitudes toward medicine and health, local customs and education.

To discuss division of medical care properly, I submit that it is necessary to define a doctor by what he does. (We must admit at once that the doctor changes with society and it is what he does and how he does it that counts. The doctor today lives in a different world and while what he does changes, his basic function is to manage patients for their welfare and benefit.)

A personal physician is the doctor who assumes responsibility for the care of an individual patient. A family physician is a doctor who assumes responsibility for the medical care of a family. A general practitioner may be a personal physician or a family physician. A pediatrician is a physican who accepts responsibility for child care, and the internist is usually a physician who accepts responsibility for the medical care of the adults of a family. Sometimes, the pediatrician or the internist acts as a consultant and accepts patients only upon referral, and then he shares the responsibility for the total care of the patient through his advice.

In my opinion, every person should have a personal physician who should be responsible for the medical care of the patient. If he feels that he needs outside help or advice, he should guide the patient to the proper facilities or doctor for help but he should continue to accept responsibility for the total care of the patient unless he discharges the patient to the care of another doctor. In many instances, this is desirable because the way the doctor manages the relationship with patients is a crucial factor in practice, and it is important for both the doctor and the patient.

When a patient has more than one doctor and there is no communication between them, then difficult situations arise and medical care of poor quality may follow as a result of conflicting information. This sort of situation should be avoided and discouraged. When it exists, it is a defect.

The merits of the division of family medical care are that if a person has a personal physician, who is competent and well trained, and knows his limitations, and a good relationship is established, the patient is likely to receive the best care.

My own opinion is that the adults of the family should have a personal physician; one who supervises and guides the patient in medical care, and one who refers the patient to another doctor for special services when they are needed, be it pediatrician, surgeon or obstetrician.

In practice, family medical care, whether it is divided or individualized with respect to specialists or family physicians, will have to be assessed upon the basis of the human relations the doctor establishes with the family or the individual patient.

I do want to emphasize that, as academic educators, we have a responsibility to the public and community for providing exemplary medical care of the sick; for improving medical care through advancing knowledge, and transmitting it for the benefit of the public. Adaptation, growth and reproduction are three phases of the living organism if it survives. So with a department, we adapt or adjust to meet a local need. We grow in order to fulfill our purpose and we reproduce personnel for continuity and succession of medical care of high standards.

Training programs for internists, pediatricians and categorical specialists should be sufficiently flexible to allow for freedom to develop specific interests without undiscriminating discipline.

The organization of medical practice must be worked out at the local community level and will depend upon what the public will accept. The local profession must set their own high standards that will be acceptable to outside professional and public opinion, and insist upon medical practice of high and ethical standards.

Improved interdepartmental relations are important and should be represented by real collaboration, as determined by working together for a common objective. This should be done to train better doctors and improve patient care.

Finally, I want to say that there is a great and urgent need for all departments in a university to relate their total programs to costs and budget. There is a great deal of education needed here—education of administrators, education of participants, and education of the public. The public is being called upon to provide more money for medical care, medical research and medical education. We need to keep the public informed about these matters so that they will continue to give us their support.

THE WHITEHEAD LECTURE

by Erle E. Peacock, Jr., M.D.

The Whitehead Society, named for Richard H. Whitehead, first dean of the School of Medicine, is the student government organization of the UNC School of Medicine. All students in the Medical School are members of the Whitehead Society. The executive body of the Society, the Whitehead Council, is composed of class presidents, an elected representative of each class, and Officers of the Society. The President of the Whitehead Society for 1962-1963 is Mr. Neil Bender.

An important part of the orientation program conducted by the Society for the first year class each fall is the Whitehead Lecture which was given this year by Dr. Erle E. Peacock, Jr., Associate Professor of Surgery.

Mr. Bender, members and guests of the Whitehead Society, and distinguished members of the Class of 1966:

You have been surfeited by words and deeds of welcome during the last few days which surely must have left no doubt in your minds as to the eagerness and pleasure with which we have anticipated your arrival in Chapel Hill. You are a select group, chosen from one of the largest and most capable groups of applicants ever to apply for admission to one of the best medical schools in the United States. That you are here is evidence that you are good, and the confidence that you are good will undoubtedly serve as a tremendous stimulus to you to keep faith with parents, teachers, selection committees and others who have aided you in attaining admission to the University of North Carolina School of Medicine.

I cannot hide from you the pleasure which I feel in being asked to speak to you on the eve of this beginning of your medical studies. My only qualifications for taking your time are that I sincerely believe the next four years will be among the happiest of your life, and that if I were faced with the same opportunity you have now, there are a few things which I would do differently than I did some years ago. It is the purpose of my talk to outline a few of these things as simply and as directly as possible.

My first objective is to point out to you the enormity of the bulk of knowledge which is to be set before you and the importance which any fragment of this knowledge may have in terms of health and happiness for those whom you will ultimately serve. In most pre-medical courses, a finite amount of knowledge is put in front of a student, and he is required to absorb and give back enough of this knowledge either to be rid of the subject entirely, or to pass on to a more advanced course. Practical use of some pre-medical knowledge is obvious in developing a well-rounded individual, but much of it has no immediate practical importance and, at best, can only be justified on the basis of being required for admission to preparation for one's life work. When you go into your first class tomorrow, however, there will be a difference. The body of knowledge confronting you is not finite. What is known is considerably more than you can master in many years of intensive study, yet a good deal of what you will need to know in the practice of medicine is not known. You are faced, therefore, with a problem of infinite proportions and with the sharp realization that there will never again be a point at which you can close your book and say, "I have mastered that subject." There will never be a time when you can feel completely confident to manage a patient because of the mastery of a subject.

The realization that the bulk of the known is too great for complete mastery and that the limits of things which are not known is infinite can be paralytic to the uninitiated as he starts the study of medicine. Perhaps many teachers contribute to the paralysis of unprepared students, for they frequently appear to act as if their aim was to cram the brain rather than to educate the person. It is not too early to emphasize to you that no one realizes more than the faculty of the Medical School that it is completely impossible to prepare you for your life's work by cramming your brain with enough useful facts to serve even one patient after you have left the confines of Alma Mater. This faculty is dedicated to one purpose—*to teach you to*

educate yourself. We do not presume to tell you how to treat abdominal pain. We will do all that we can to teach you how to study abdominal pain, however, and tomorrow morning you will begin to learn how to study anatomy as part of that preparation. You will probably find that certain anatomical facts will have to be relearned at least three different times—on your cadaver, at the autopsy table next year, and at the operating table or in the hospital ward at a still later period.

Recently I showed a group of students in surgery a microscopic slide of diseased tissue to which I was quite certain they had never been exposed either in practice or in theory. I asked them to study the slide and to write a short critique on the prognosis of the patient. Although most of the students seemed to enjoy the exercise, a few were obviously quite disgruntled. After the session was over, I questioned some of these students a little more intensively. One of them was quite outspoken, and finally blurted out, "We pay you to teach us these things." The obvious answer, even to you at this stage, is that you don't pay your faculty to teach you anything. You pay them to teach you how to teach yourselves. The facts are available for you in books, laboratories, and in patients. The best that your faculty can do is to try to help you learn to assimilate these facts, call them up when needed, and try to understand the problems of disease and injury on the basis of sound scientific fact.

I think you will find that you will be exposed to knowledge of four types. The first type I will call hearsay knowledge, because it is the type picked up during dormitory bull sessions, at lunch, or in the halls where formal education has not been planned. Such knowledge is valuable only in so far as it stimulates curiosity to verify or discredit. It can be extremely dangerous if it is blindly accepted because it is reported to have come from an authoritative source. This type of knowledge is extremely abundant around periods of examinations, when some students will try to build up their own confidence by speaking loosely and using words which do not hold true meaning for them. The syndrome memorizer is a good example of this practitioner, because, as you enter the study of clinical medicine, you will find that eponyms have been used to categorize various groups of symptoms to give the impression that the entire pathology, physiology, and treatment for the disease is understood. I have a favorite such syndrome I used to upset the syndrome memorizers in my own class. It is the syndrome known as Coast's disease, a term which can be discreetly dropped as if everyone should know its full meaning. Only by persistent delving into abstract literature can one find the disease which is due to cobalt deficiency in a specialized breed of cattle.

A second type of knowledge which is also, in my opinion, a rather vague experience is knowledge which I will call empirical knowledge—in a derogatory sense. It has been the basis for a great deal of treatment which is given not because of scientific formulation or experimental tests but by the "general impression" that it "usually" works. The history of medicine is filled with ridiculous ends to which such knowledge has led us. Not many years ago pulmonary congestion was nearly always treated by bleeding the patient. There was no evidence that the patient had a problem of increased blood volume, yet the fact that this treatment sometimes worked was given as a reason for doing it routinely. Actually, bleeding did improve some patients. It was not

until some years later, however, when methods of diagnosis and understanding of the pathologic physiology made it possible for us to determine the difference between pulmonary congestion due to failure of the heart and pulmonary congestion due to infection with pneumococcal bacteria, that venotomy was put on a rational therapeutic basis. Bleeding is still occasionally used with good results in the emergency treatment of heart failure due to high blood pressure, but it now appears to be ridiculous beyond measure to treat pulmonary congestion from other sources by opening a vein and relieving the patient of some of his blood volume.

A third type of knowledge is that obtained by immediate deduction, or knowledge reached by reasoning. This kind of knowledge is superior to the other two but is precariously subject to sudden refutation by direct experience or measurement. Some years ago, the Washington Red Skin professional football team was training in Chapel Hill for an exhibition game with the Green Bay Packers. On the afternoon before the game, the trainer appeared at the hospital and offered several tickets to the game if someone from the surgical staff would sit on the bench and act as the team doctor. I was the chief surgical resident, and being well primed with knowledge of all three types, I accepted the invitation. Midway during the second quarter, a mammoth Redskin tackle was laid prostrate on the field, and the officials and trainers began calling for the "Doc". I suddenly realized that 40,000 people were waiting for me to examine the man, and I must admit I felt somewhat of a sense of panic. I was quickly reassured, however, for when I turned back his eyelids and found one pupil much larger than the other and completely nonreactive, I knew precisely what the situation was and what had to be done. Any third year medical student should recognize the extremely dangerous sign of rapidly increasing intracranial pressure, and knows that the patient must be placed under experienced neurosurgical attention and possibly operated upon as an acute emergency. I explained this with great authority to the officials, and during the ten minutes it seemed to take before an ambulance could be gotten to the field and preparations made to move him, I felt very confident of my deductive reasoning. Before the patient could be loaded in the ambulance, however, in front of 40,000 people, including my own chief, the patient began to struggle violently. In a few seconds he was on his feet demanding to be put in the game. The pupil was still dilated and fixed, and it was only a few moments later I learned that, of the 100 eyes on the Washington Redskin football team I had rolled back the lid over the one glass eye in the whole outfit.

It follows, therefore, that the highest kind of knowledge is the form which comes by direct perception. It is upon this type of knowledge that the soundest part of your medical education will be based. This type of knowledge will make it possible for you to practice medicine as the highest type of measurable science. There can be no doubt that medicine, like other sciences, is becoming a science of measurement, and that only by accurate and precise scientific measurements will we be able to arrive at truth. We have to know what is *there*. It is so easy to lie to one's self, but, even at the crudest level, observations must not be faked. We often take truth for granted; yet it is truth which differentiates science—in its widest sense—from all other intellectual activities.

If these, then, are the types of knowledge, and the enormity and infiniteness of the amount of knowledge are such that we cannot hope to encompass it all, what is the plan by which a first year medical student may learn to educate himself?

It seems to me that the first thing to do is to realize the importance of a plan. Let me hasten to caution that a plan stubbornly followed without flexibility or recourse to change can in itself be disastrous. I am convinced, however, that, when faced with as formidable a task as that of acquiring a medical education in 1962, some type of flexible plan is essential for doing the best with the time allotted. Mercifully, during the first two years, the plan for your activities during the day has already been made for you. For the next two years you will be told, for the most part, where to go and when to be there, and given some idea what you will be expected to cover. During the final years, however, there will be a good deal of the day when you will not be told to do anything. There will be a tremendous number of educational experiences going on around you in the wards and operating rooms of the hospital, and it will be up to you to decide how you will spend your time to best advantage.

Above everything else, the plan must have an objective. I strongly feel that there should only be one objective—quality. As was pointed out by Dr. Louis Welt in a previous address to the Whitehead Society, there is very little mathematical probability that you are going to fail the medical course. The big question you have to decide is how good you are going to be. I am realistic enough to be aware that everyone cannot be on the top rung of the ladder. But I also know that everyone can raise himself a little higher, to relieve the terrible congestion on the bottom rung. Your objective is not to pass the work in this medical school. You have got to have a plan that has as its objective to be a superior student. Your objective must not be merely to have an internship—your objective has got to be to have the best internship. You cannot have as an objective to pass the specialty boards in a clinical practice. You have got to have, as your objective, the goal of being a leading or top man in your chosen field. The failure to have an objective is so often the failure to excel. Nothing is more certain to assure you of a mediocre record in this medical school and a mediocre post-graduate training program and a mediocre service in the field of medicine than to plan for nothing more than mediocrity at the very beginning. You are the elite of several hundred candidates to this medical school—see that your objective is to be the elite of the graduating students in medicine in this country. In no other way can you keep faith with those who have bet on you. We did not admit a single student to this medical school with the idea that he would be in the lower third of his class. Those who end up in the lower third of their class are, for the most part, those who had no other plan of their own.

The most important part of a plan for your four years in medical school, other than the objective, is a plan for organized study. Let it be said right now that there is nothing easy about attaining a medical degree. Physically, mentally, and morally, you will find it easier to attain doctorate status in any other field than medicine. You would not want it any other way. Already there are many examples around you which make you know that anything which is worth having must be sacrificed for. Only those things which re-

quire great sacrifice are worthy of being a final objective; in choosing the objective of admittance to the medical profession, you have also chosen sacrifice and hard work.

It is quite possible that many of you have never learned to concentrate for two or three hours at one time, because you never had to do so. By determination and self discipline, you are going to have to learn to do just that: To set aside a time for concentrated study and to hold that time more sacred than anything else you do. The old joke about the freshman medical student who dropped his pencil during the first lecture and was six weeks behind before he picked it up is more fact than fiction. You cannot afford to miss a night. Before long it will become habit, and much easier than in the beginning. If, however, you fail in the beginning to discipline yourself to set aside a time in the evening or early morning hours in which you can have uninterrupted concentrated study, you will never fulfill your potential in this medical school.

By now you know how many hours sleep it is necessary for you to have to perform effectively. Your plan must include this period of time, and discipline will often be required to be assured that it is fulfilled. It is stupid to sleep in class. To sleep in class is to make a public demonstration of the fact you lack an adequate plan or to demonstrate that you are either bored or completely overwhelmed with the subject matter at hand.

As a medical student you will be exposed to certain diseases, and participate in physical exertion which will require that you be in top physical condition. To this end, it is extremely important that you eat three good meals a day. Tuberculosis, peptic ulcer, and certain stress conditions most often appear in medical students who have a history of missing meals or substituting a cigarette for a meal—generally the result of poor planning or the complete lack of a plan. I see no point in taking up your time with a plan for recreation. Carolina students have seemed to solve this problem over the years, and I have no doubt that you will also.

Although I have no intention of advising or interfering in one's personal religious life, I cannot help but advise that a plan include attendance at church on Sunday. At the very least, this assures you of at least one hour during the week when you can sit relatively undisturbed and reflect about whatever comes to mind.

You will note that I have been very careful not to try to set up a specific plan for any of you. My purpose instead has been to emphasize to you the importance of *a* plan. You will have to decide whether you study best in the early evening, the late evening, or the early morning hours. All I want to do is to coerce you to spend some time during the next few hours deciding upon a plan with the highest objective—and finding within yourself the grit and guts to adhere to the plan as long as it appears to be the best one for you.

Much has been written and much research has been done on the subject of success. After a long study of the problem, a graduate student once wrote to his father, "I have not yet found the key to success, but I am getting very much afraid that it is hard work." Medical school will be the most gratifying hard work you have ever done because for the first time, perhaps, it will be hard work with a purpose, which I might add is recognized through-

out the world as the most unselfish of all professions. From the first lecture on the first day, a direct application of what you are learning to the needs of people in trouble will be obvious; this applicability should give you a lightness of heart and springiness of step that will make it possible for you to sacrifice as you have never sacrificed before.

The greatest threat to any plan which you may devise tonight is the threat of disappointment and temporary failure. Such disappointment or realization of failure usually takes the form of an examination or oral quiz. Not one of you will escape this type of disappointment. This faculty knows that the weakest point in our educational system is the ability of a faculty to examine and evaluate its students. No matter how hard you work, how much you learn, how noble your ambition—you are going to get caught. You are going to get caught short on an examination, and you are going to get caught short on a patient. A student whom I had personally coached in preparation for an examination, and who did not do as well on the examination as he felt he should have, came into my office recently to apologize and bemoan the result of the examination. The tragedy, in my opinion, was not that the student did poorly on the examination. That was over and done with, and too many important examinations are ahead. The tragedy was the failure to realize that even when he had done his best and felt prepared, he could fail so badly. The most intriguing facet of the study of medicine is that you can never master it completely. So often when one just begins to feel that he is understanding or getting on top of a medical problem, it will rise up and smite him down, whether in the form of an examination or a tragic complication in a seemingly properly handled patient. Know that this is going to happen to you; be prepared to take it when it comes, and somehow, develop as early as possible the attitude expressed at the upper left hand corner of an envelope I saw recently which said, "if not delivered in five days, try like hell the sixth."

You are going to hear that class standing and grades are unimportant, that one should not worry about such things in medical school. I think that this is an insult to your intelligence. Of course, you did not come here for the sole purpose of making a grade or passing an examination. You came here to learn the art and science of medicine. But you know without being told that you have to be evaluated and that the opportunities which will be open to you are going to be dependent upon the type of grades which you attain. Grades are tremendously important, and unfortunately, because of the limitations in methods of testing, it is inevitable that you are going to be unfairly and inadequately tested at some time during the next four years. Discouragement, when this happens, can be dangerous. Somehow, as soon as possible, you have got to develop the philosophy and shrugging motions of the old horse that accidentally fell in the well. The well was not too deep, and it had been dry for many years. The horse was not too good, and so the farmer decided the best way to settle the situation was to throw dirt in the well until he buried the horse and covered the well at the same time. With each shovel full of dirt, the horse developed a shrugging motion, shaking the dirt to the ground and stamping on it. With each shovel of dirt which was shrugged off and stamped under foot, the horse raised himself higher and higher in the well. Before long the horse was standing on dry land, because *he refused to be buried*. Learn the shrugging, stamping motion, and refuse to be buried.

The lessons from the worst failures are the most important ones that we have. Every experience will be valuable in the learning process. I do not know if anyone ever considered me as a likely candidate for a pediatrician, but I never considered being a pediatrician, and I know the reason why. The first pediatric patient I was asked to examine was a tiny colored infant lying in the arms of a 350 pound Negro mother. She said, "This baby squalls and squalls and the only way I can get him to stop squalling is when I feeds it. I don't mind feeding it except that it squalls so much I's almost run dry." Then the baby started to scream its head off, and being unable to examine it in that condition, I instructed the mother to feed it until it stopped crying. She exposed a tremendous left breast and began to try to feed the child, who paid no attention and only intensified its screaming. With a note of desparation, she finally began to spank the baby on top of the head and said, "Hesh up you little nob head, hesh up afore I gives your dinner to the doctor man." Believe me, failures make a great impression and much can be learned from even the most frustrating experience.

The one great cause for human failure is an alibi. An alibi will be your personal enemy number one. It is not merely an excuse for failure, but is often a rationalization, which means a ready excuse. How often the case has been, however, that success has not been in spite of a handicap; it has been because of a handicap.

Because it seems so pertinent at this time, I would like to close with one illustration which perhaps many of you know in detail. I believe that this account is accurate as it involves the life of William Ernest Henley. As a small boy living in Edinburgh, he had a chronic condition in his leg which led his doctor to say he could not help him and that the only doctor who could help him lived in London. As you know, it was before the days of hitch hiking, and apparently, it was with great difficulty that this lad made his way by train, cart, and walking to the outskirts of London. If the facts which we are given are accurate, conditions were so bad, and the legs were in such condition by the time the boy reached London, that he actually made the last few miles on his stomach, crawling to the address of the bone specialist who was to help him. Apparently it was necessary to amputate one of the legs immediately in order to save the boy's life. Over the course of the next three months, a great deal of work was done in an attempt to save the other leg. As it appeared the other leg might have to be amputated also, the surgeon arranged for a consultation with several other reknown specialists who were meeting in London at the time. During the course of their consultation in an adjacent room, William Henley wrote on the back of the nurse's temperature sheet the immortal poem *Invictus*, which included this determination:

> It matters not how straight the gate,
> How charged with punishment the scroll;
> I am the master of my fate;
> I am the captain of my soul.

Invictus—unconquerable, insuperable, indomitable—the only answer I know for those who would advise you to shun the call to perfection. It is the challenge we put before you on the eve of this, your most exciting adventure. Your accomplishments in the past leave great hope that this challenge will be met in full.

The Class of 1966

Name	*Undergraduate College*	*Residence*
James Curtis Abell	Univ. of North Carolina	Yanceyville
James David Alford	Univ. of North Carolina	Zebulon
Willis Arthur Archer	Univ. of North Carolina	Salisbury
Frank Walton Avery	Univ. of North Carolina	Winston-Salem
Rudy Watkins Barker	Univ. of North Carolina	Carrboro
Robert Phillips Barringer	Davidson College	Newton
Joseph O. Bell, III	Univ. of North Carolina	Tuxedo
Garry P. Bergeron, Jr.	Univ. of North Carolina	Farmville
Robert Hodges Bilbro	Univ. of North Carolina	Greenville
William Hampton Bowers	The Citadel (UNC Graduate School)	Melvin Hill
Paul Leach Burroughs	Univ. of North Carolina	Raleigh
Daniel Malloy Calhoun, Jr.	Davidson College	Elizabethtown
Timothy Earl Cloninger	Davidson College	Newton
Earnest Swindell Collins	Univ. of North Carolina	Nashville
George Wheeler Cox	Univ. of North Carolina	Charlotte
John Robert Crawford, III	Univ. of North Carolina	Salisbury
Joseph Bernard Credle	Univ. of North Carolina	Ahoskie
William Monroe Crutchfield	Univ. of North Carolina	Pittsboro
Nelson Park Davis, II	Duke University	Jamestown
Philip Carl Deaton	Univ. of North Carolina	Greensboro
Wesley Caswell Fowler, Jr.	Univ. of North Carolina	Dunn
Thomas Nash French	Davidson College	Reidsville
Edgar Cornelius Garrabrant	Univ. of North Carolina	Wilmington
Robert Clayton Gibson, III	Univ. of North Carolina	Winchester, Va.
Carroll Lee Gray	Univ. of North Carolina	Franklinville
Cyrus Leighton Gray, III	Duke University	High Point
George Talmadge Grigsby, Jr.	Univ. of North Carolina	Holly Springs
Carol Anne Hedden	Duke University	Lenoir
Ronald Jay Hickes	Univ. of North Carolina	Charlotte
Lewis Patterson Hicks	Univ. of North Carolina	Wise
Howard Thomas Hinshaw	Guilford College	Greensboro
Nelson Neil Howell	Univ. of North Carolina	High Point
William Colvin Hubbard	Univ. of North Carolina	Raleigh
Theodore Hyde Kiesselbach	Univ. of North Carolina	Media, Pa.
Thomas Jeffrey Koontz	Univ. of North Carolina	Lexington
Sidney Carl Kress	Duke University	Wadesboro
Arthur Eldridge Leake, Jr.	Univ. of North Carolina	Marshall
Hugh Talmage Lefler, Jr.	Univ. of North Carolina	Chapel Hill
Jacob Andrew Lohr	Univ. of North Carolina	Lexington
Wyndell Hunt Merritt	Davidson College	Chapel Hill
Peter Lorenz Morris	Notre Dame University	Charlotte
Duncan Morton, Jr.	Davidson College	Charlotte
Larry Mumford	East Carolina College	Pikeville
George Marion Paddison	Univ. of North Carolina	Smithfield
Roy Kenneth Pons	Univ. of North Carolina	Valdese
James Allen Pressly	Davidson College	Kings Mountain

Name	*Undergraduate College*	*Residence*
Don Warren Printz	Duke University	Asheville
William Cleaton Rawls	Davidson College	Rocky Mount
Karl Arthur Ray	Duke University	Greensboro
Alvis Marvin Rich, Jr.	Univ. of North Carolina	Burlington
William Barker Riley, Jr.	Univ. of North Carolina	Chattanooga, Tenn.
William Earl Roberson	Davidson College	Greenville, S. C.
Surry Parker Roberts	Univ. of North Carolina	Durham
Charles Kimrey Scott	Univ. of North Carolina	Haw River
Robert English Sevier	Univ. of North Carolina	Asheville
James Lewis Sigmon, Jr.	Univ. of North Carolina	Newton
Robert George Simmons	Univ. of North Carolina	Roseboro
Herbert Lee Smyre	Univ. of North Carolina	Newton
John Wilder Southard	Univ. of North Carolina	Bethesda 14, Md.
Elizabeth Harrison Spivey	Univ. of North Carolina	Williamston
Verner Eugene Stanley, Jr.	Davidson College	Charlotte
Walter Franklin Steele	Duke University Univ. of North Carolina	Hickory
Elliott Walker Stevens, Jr.	Univ. of North Carolina	Warsaw
Harold Lewis Tarleton	Univ. of North Carolina	Monroe
Donald Anton Thomas	Univ. of North Carolina	Roanoke Rapids
Henry Fuller Thomas, Jr.	Davidson College	Spindale
William Beverly Tucker, III	Univ. of North Carolina	Hertford
William Hunter Vaughan	Univ. of North Carolina	Tryon
James Hubert Whicker	Univ. of North Carolina	North Wilkesboro
James Alvin Yount	Univ. of North Carolina	Claremont

presenting... The Alumni

DR. ARTHUR HILL LONDON, JR.

Dr. Arthur Hill London Jr., clinical professor of pediatrics, is a native of Pittsboro. He received his B.S. in Medicine from the University of North Carolina in 1925 and his M.D. in 1927 from the University of Pennsylvania.

Dr. London began his teaching career at the University of Pennsylvania, where he was an instructor in pediatrics, in both the medical school and the postgraduate program, from 1929 to 1930. He left the university in 1930 to engage in private practice and he joined the UNC medical faculty in 1937.

He has served as chairman of the North Carolina Medical Society Pediatrics Section as well as secretary of the Durham County Board of Health. He is a former president of the Durham-Orange County Medical Society and a former district chairman of the American Academy of Pediatrics.

From 1948 to 1951 he was a Southern Medical Councillor and in 1949 was district chairman and an executive committee member of the state Medical Society. He has also been a member of the American Academy of Pediatrics' National Executive Committee.

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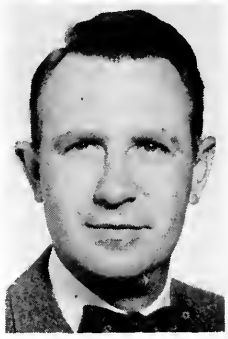
DR. CHARLES A. SPEAS PHILLIPS

Dr. Phillips is a native North Carolinian. A Phi Beta Kappa here, he received his B.S. in Physics in 1942. After two years in the UNC School of Medicine, he attended Northwestern University where the M.D. degree was awarded in 1947. Following an internship at Cook County Hospital in Chicago and residencies in General Surgery and Urology at the Veterans Administration Hospital, Hines, Illinois, he served three years in the U. S. Navy as a Flight Surgeon.



In 1954, Dr. Phillips joined and has remained in the staffs of Moore Memorial Hospital, Pinehurst, and St. Joseph's of the Pines Hospital, Southern Pines, as attending surgeon. At present, he is Chief of Staff of Moore Memorial Hospital. He is a member of many professional societies including the American College of Surgeons, American Geriatrics Society, and New York Academy of Sciences.

Dr. Phillips' chief hobby is flying, and he is a qualified commercial pilot with instrument rating. This enables him to make a quick trip to Chapel Hill

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presenting... The Faculty

DR. GORDON SHELDON DUGGER

Dr. Gordon Sheldon Dugger joined the faculty of the School of Medicine in 1954. He is an associate professor of surgery specializing in Neurosurgery.

A native of Vilas, N. C., Dr. Dugger received his A.B. degree from the University of North Carolina in 1941. His M.D. degree was awarded by Johns Hopkins School of Medicine in 1945, and he served his internship in surgery at North Carolina Baptist Hospital. He was trained in Neurosurgery at the Montreal Neurological Institute of Montreal, Canada.

From 1946 to 1948 he served in the Army Medical Corps with the rank of captain. After the war he became a staff physician with the Oregon State Hospital in Salem. From there he went into private practice for a year at St. Helen's, Oregon.

He was assistant resident in neurology at the Montreal Neurological Institute during 1951. At the institute he held consecutively the posts of Senior Fellow in Neuropathology, Neurosurgical Assistant Resident and Neurosurgical Resident.

In 1957, while an assistant professor of surgery at UNC, he was awarded a three-year grant from the Public Health Service for study of the effects of pituitary gland operations

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DR. GEORGE R. HOLCOMB

Dr. Holcomb is a native of Illinois and completed his educational training at the University of Wisconsin, receiving his Ph.D. in anthropology in 1956. After three years as an instructor in anatomy at Creighton University Medical School, he joined this faculty in 1957 as an Assistant Professor in the Department of Anatomy.

In addition to his teaching duties in the Department of Anatomy, Dr. Holcomb also teaches in the Department of Sociology and Anthropology. He has recently been appointed Associate Dean of the Graduate School for Research Administration.

Dr. Holcomb is a member of the American Association for the Advancement of Science (Fellow, 1956), American Anthropological Association, (Fellow), American Association of Physical Anthropologists and American Association of Anatomists.

He is married to the former Miss Ellen Jean Jacobsen of Racine, Wisconsin, and they have three daughters.

Presenting the House Staff

DR. WILLIAM M. CLARKE

Dr. William M. Clarke received his AB (1954) and M.A. (1957) degrees from Duke University where he was a research associate in the Department of Zoology (1956-57). His medical degree was awarded by the University of North Carolina in 1961. In 1961-62 he was an intern in pediatrics at North Carolina Memorial Hospital, and at the present time is a first year pediatric resident at this institution. He is the recipient of a 2-year Wyeth Pediatric Fellowship.

Dr. Clarke won the Deborah Leary Award for the outstanding thesis of his graduating class for his work upon lens development and has contributed a number of articles in this field. As a member of the house staff, he has maintained an active interest in research while continuing his development as an outstanding clinician.

He is the son of Mrs. M. J. Clarke of Fayetteville and is married to the former Miss Dorcas Gaines. They are the parents of two boys.

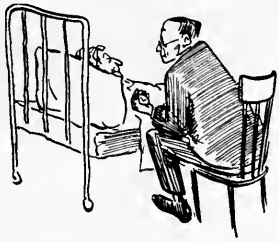
ALUMNUS HONORED . . .

At the invitation of the Swedish National Association Against Heart and Chest Disease and the Swedish Medical Society, Dr. H. McLeod Riggins, '22, gave a lecture entitled "Primary Bronchogenic Carcinoma" in Stockholm on September 4, 1962. On this occasion, Dr. Riggins was awarded the 150th Anniversary Medal of the Swedish Medical Society in recognition of his work in the field of respiratory disease.

He also gave a paper on this subject on September 6 in Munich, Germany, at a meeting of the International Congress on Internal Medicine.

Dr. Riggins has lived and practiced mainly in the New York area, living in the city during the winter and in Greenwich, Connecticut, during the summer months. He is Visiting Physician (Chest Service), Bellvue Hospital and Associate Clinical Professor at the College of Physicians and Surgeons of Columbia University.

A past president of the American Trudeau Society and National Tuberculosis Association, Dr. Riggins was for several years out of state counsellor for the U. N. C. Medical Alumni Association.



ALUMNI NEWS ITEMS

CLASS OF 1923

Dr. Roy W. Upchurch, 506 Hawthorne Drive, Danville, Virginia. Does genito-urinary surgery; had his postgraduate training at Columbia University. Certified by the American Board of Urology, Dr. Upchurch is a Fellow of the American College of Surgeons and is a member of the American Urological Association. He and his wife, Mae MacDaniel, have two daughters, Susie and Peggy, and a son, Roy, Jr. Susie married Dr. Don Keller and lives in California. Peggy married Dr. Art David and they live in Jacksonville, Florida. Roy, Jr. (UNC '57) married the former Miss Nina Skinner and they live in Durham where Roy, Jr. is employed with Liggett and Meyers Tobacco Company.

Clyde Reitzel Hedrick, P. O. Box 619, Lenoir, North Carolina. Does general practice and cardiology; had postgraduate training at Stuart Circle Hospital, Richmond, Virginia, and Cook County Graduate School, Chicago, Illinois. An elder and chairman of Consistory, Zion Evangelical and Reformed Church, member of Kiwanis, Pythian, and Moose Clubs, Dr. Hedrick enjoys fishing for recreation. He and his wife, Stella, have three married daughters, Theresa Sherman, Marlene Neisler, and Phyllis Miller.

CLASS OF 1924

John William Ormand, Sr., P. O. Box 397, Monroe, N. C. Does general practice and E.E.N.T.; had his postgraduate training at University of Cincinnati, Washington University at St. Louis, Chicago E.E.N.T. Hospital and University of Rochester. An elder in the First Presbyterian Church, Dr. Ormand has served both as councilor and President of District 7 Medical Society. He married the former Louise Alida Thoman and they have two sons, John W., Jr. and Thoman Lane, both physicians.

PARENTS' CLUB AFFAIRS

Region V of the University of North Carolina Medical Parents Club held a meeting Saturday, September 22, at the D. R. Printz residence in Asheville.

Region V includes Burke, Caldwell, McDowell, Mitchell, Cleveland, Gaston, Lincoln, Rutherford, Buncombe, Haywood, Henderson, Transylvania, Cherokee, and Jackson Counties.

Welcoming and opening remarks were made by C. G. Pickard of Asheville, Regional Chairman. Mrs. Zebulon Weaver of Asheville, chairman and fund trustee of the Student Emergency Loan Fund, gave a report on the fund.

The Medical Parents Club consists of the parents of all students of the UNC School of Medicine, past, present, and future.

Its purpose is to keep all parents of medical students informed about the total program of the School of Medicine, and to foster a close and enthusiastic Medical School-Parent relationship.

Dr. Carl Anderson, assistant dean for student affairs, and Emory S. Hunt, assistant director, The Medical Foundation of North Carolina, Inc., attended the meeting as representatives of the School of Medicine, and made brief talks on recent developments at the School and plans for the future.

— DR. LONDON —

(Continued from Page 34)

Dr. London, in addition to his teaching activity at UNC, is an assistant professor of pediatrics at Duke University and chief of pediatrics at Watts Hospital in Durham.

— DR. PHILLIPS —

(Continued from Page 34)

once a week, which he has been doing since 1957. As clinical assistant professor, Dr. Phillips may be found each Wednesday morning in the gross lab teaching anatomy to first year medical students.

— DR. DUGGER —

(Continued from Page 35)

on patients with cancer.

Dr. Dugger, whose hobby is the study of history, is a member of the Congress of Neurological Surgeons, the Harvey Cushing Society, and Southern Neurological Society.

Vol. X DECEMBER, 1962 No. 2

THE BULLETIN

School of Medicine
University of North Carolina

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5,000	7,500 to 15,000	75.00 Weekly	114.00	57.50	152.00	76.50
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THE BULLETIN

of the School of Medicine
of the University of North Carolina

Published in cooperation with the Whitehead Medical Society
and the Medical Foundation of North Carolina, Inc.

Vol. X December, 1962 No. 2

IN THIS ISSUE

Editorial Committee

Address all inquiries and communications to Emory S. Hunt, 117 Medical Science Building—or Box 957, Chapel Hill, N. C.

Published four times a year — October, December, February and April — Entered as third-class matter at the Post Office at Chapel Hill, N. C.

Ruth Faison Shaw

Creator of Fingerpainting

By Ellouise Schoettler

"UNLESS YOU CAN give some measure of pleasure to someone—you haven't done a worthwhile thing," Ruth Faison Shaw told me as we sat sipping coffee in her work-room in the Psychiatric Unit. Certainly she has achieved her goal through her creation, fingerpainting, by bringing recreation and pleasure to countless thousands as well as the release of tensions and conflicts afforded others through skilled application of the art and clinical interpretation of their paintings.

Our conversation ran a real gamut of subjects. She even took time out to give me some advice on child-raising. Harried mother of four, I leaned forward eagerly on the edge of my chair. "Relax and enjoy them," she laughed. "There's nothing like an old maid for giving advice about children." After all her years as a gifted teacher there wouldn't seem to be a better qualified authority.

Being with Ruth Shaw is an experience. She is completely charming—radiating warmth mingled with flashes of humor. Quick to laugh, she is even quicker to deny her own importance. She is an artist—although she jokingly says fingerpainting was derived for her pleasure as she never could paint—but the most striking facet of her artistry is her facility with people. A friend of hers remarked, "Everywhere you go with Ruth Shaw is a picnic."

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* Mrs. Schoettler is the wife of a Resident in Psychiatry here. Combining writing with her duties as a housewife, she has had articles in *Resident Physician* and elsewhere.

Miss Shaw's whole face betrays the sincere affection she feels for her patients as she relates their problems and accomplishments. It is no wonder that the affection is reciprocal. A patient recently wrote of her:

> "I was excited over the prospect of something new in my life to break the monotony of passive daily living. Having met Miss Shaw I was almost overwhelmed by her magnificent personality. Just to be with her was an inspiration in itself. I felt compelled to attempt constructive response."

Ruth Faison Shaw originated fingerpainting in the mid-twenties. At the time she was teaching in her own school in Rome. The idea sprang from the need of one of her pupils to "smear." The child smeared the bathroom walls with iodine and it seemed so much fun that the other children wanted a turn too. This set Miss Shaw on the trail of the formula that would be fingerpaints. The aim was to perfect a color substance children could use with their bare hands; safe to the skin and harmless if eaten.

Miss Shaw says that her school wasn't planned as "progressive." The question seemed logical after the iodine anecdote. Her explanation of her school was simple and straight to the point as well as delightfully honest. "It was mine. I did what I wanted to and I had a wonderful time." The children did too. At a tea, a child in Miss Shaw's hearing was asked, "Do you go to Miss Shaw's school?" "No," came the emphatic reply. "But," the inquirer persisted, "your

mother told me you did." "No, *you* say I go to Miss Shaws *school—I* go to Miss Shaw's *parties*."

Once the formula was perfected and she began using fingerpaints with her pupils it didn't take Miss Shaw long to recognize the overwhelming potential of the media. In what she had thought to be an intriguing new play technique lay untold possibilities for creative education.

The innovation first came to the foreground at the International Congress of New Education in Nice. An exhibit of fingerpaintings by Miss Shaw's pupils was an instant sensation. Fingerpainting became the center of attention and object of speculation. Almost overnight Miss Shaw and her work were transferred from relative obscurity to prominent acclaim. They were subjected to careful scrutiny by educators as well as medical personnel. The curiosity of "medicine" was aroused when stutterers and bedwetters were greatly helped when allowed and encouraged to express themselves freely on paper. Conflicts otherwise undetected were revealed and subsequently resolved. "Fingerpainting gives color and form to thoughts for which children often know no words," is one explanation given by Miss Shaw.

The initial flurry has since subsided. Today fingerpainting is accepted in educational circles as a valuable means of allowing the young child to express himself creatively. It took some time to re-educate teachers to the idea that fingerpainting was not just a time filler to while away frustrating rainy days. Children all have a deepseated need to create but this potential won't flourish without encouragement. Here fingerpainting comes in, and this is why Miss Shaw feels that this remains the most important use for the media.

Memorial Hospital claims a full slice of Miss Shaw's time these days. Fingerpainting has proved itself to be a useful adjunct to psychiatric diagnosis and therapy, so her heaviest load is with psychiatric patients although she does have some medical cases. In addition to working with patients, she teaches classes in fingerpainting to residents and other psychiatric personnel so that they can extend fingerpainting into their own work.

The patients in Gravely, the tuberculosis sanatorium, have plenty of time on their hands. Miss Shaw crosses the street from neighboring South Wing carrying with her paint and paper. Getting some paint on those idle hands relieves their boredom and gives a lift to their hum-drum hours.

"Fingerpainting is rehabilitation made easy through fun. Further, it fulfills that intrinsic need so inherent in all of us—self-expression through creativity. We, the debilitated, yearn for such an outlet and are fortunate indeed that we can be exposed to fingerpainting . . . for when Miss Shaw told me that cerebral palsied children can and do fingerpaint, I saw it as challenge to most all the debilities."

The woman who wrote these sentiments has myasthenia gravis and is a patient Miss Shaw has now. Until the onslaught of her illness, she led a happy and extremely busy life. A widowed mother of three, her fruitful career as a public health nurse was their sole support. Miss Shaw beams with pride and pleasure over her progress, not only for the artistic skills she is developing, but for the way she is utilizing fingerpainting in both her emotional and muscular readjustment.

"Fingerpainting is life because it is movement. Anytime there is movement there is life." This axiom is Miss Shaw's own. No background of extensive training is necessary to fingerpaint. It is simplicity itself because there are no

hampering tools of the trade to restrict the beginner. Miss Shaw says most people take readily to fingerpainting and most times through it relive a pleasurable experience. The elements of the media themselves—water and soft squishy paint—are reminiscent of the mud pies most children revel in. Another attribute is its "quickness." It takes little time to complete a picture and then the artist has his or her creation.

I was intrigued by one observation Miss Shaw mentioned. It concerned the difference in men and women—in their approach to painting. A man plows in and goes to work with a great deal of vim and vigor. He does not stop until his idea is completed on the paper. A woman, on the other hand, will paint vigorously for a time, then pause as though interrupted. She waits a moment and then returns to her work. Miss Shaw feels this is analogous to differences in their routine daily lives. Women, usually in the home, are continually interrupted by children, the phone, door-bell, while men "at the office" are permitted by circumstances to finish their work relatively free of interruption. Miss Shaw's

own astuteness in observing people is exemplified in this but also there is illustrated the way in which personality patterns may be revealed through fingerpainting.

Fingerpainting, properly utilized, is also a bridge of communication with the mentally retarded. A retarded child often cannot wield a brush with the dexterity to paint acceptably in the usual way. Using fingerpaints, however, and their ordinary body movements, they can create a thing of beauty which can be praised quite honestly as an artistic creation. Through this recognition the retarded can gain a feeling of adequacy not otherwise available to them. Relaxed, they can then begin to release some of their pent-up frustrations onto the paper and perhaps for the first time communicate with someone.

Three years ago Miss Shaw returned to her native North Carolina and Chapel Hill ostensibly to retire. Obviously, she is anything but. In addition to her work at Memorial, she teaches classes in the art, exhibits her own and her pupils' work, as well as being a gracious and willing guest speaker in and around this area.

Her white frame bungalow on Estes Drive declares itself SUMMER HILL by a sign at the walkway. The bitter October afternoon of her latest backyard exhibit, this sign expressed a popular "wish." The fences were almost obscured by numerous vari-shaped paintings on display. One glance at these brought home the fact that fingerpainting certainly should not be disregarded as an art form in its own right. It takes a second thought to comprehend that the lovely paintings were done in the same paints and similar manner as that used by small children. The techniques were infinitely more sophisticated and the subjects anything but childish. They ranged from still life's to modern abstracts to nudes—a far cry from the kindergarten work-table.

Bustling happily through the mingling crowd was a white-haired figure bundled warmly against the cold. A blue wool beret was perched on the back of her head. Ruth Shaw chatted gaily with everyone showing real pride in the handiwork of her pupils. A smattering of paintings from her own permanent personal collection was tucked away in a back corner of the garden. The only other things in sight signed RFS were some souvenirs of the showing. In these small squares which predominately were pairs of fawns done in black on white was the touch of the master.

After being with Ruth Shaw and talking about fingerpainting, it is easy to think of the two synonymously and speculate that perhaps the Magic of Fingerpainting IS Ruth Faison Shaw. This assumption doesn't hold though because over the years fingerpainting has proved itself on its own merit. The media has been used educationally and medically as well as artistically all over the world with success, and will continue to be.

Sentimentally though . . . once you've met Miss Shaw and seen fingerpainting "it gives a measure of pleasure" to irrevocably connect the two.

The New Department of Hospital Administration

THE RESPONSIBILITY OF Schools of Medicine for a wide variety of extension services directed to physicians in private practice has been accepted for many years. The responsibility of Schools of Medicine for extension services to hospitals and to their personnel, however, is a new concept to be pioneered by U.N.C. Actually, this concept is in keeping with the announced responsibilities of the University which considers the entire state to be its campus and service to its citizens of equal importance with the education of its student body. Furthermore, it is in keeping with the spirit of the 1946 Sanger Report which served as the template for the organization and construction of our present expanded School of Medicine.

It is with this thought in mind along with the widely recognized needs for further education and research in hospital administration that led to the creation last July of a new Department of Hospital Administration. Dr. Robert R. Cadmus, a graduate of Columbia University's College of Physicians and Surgeons, has been named Chairman of this new section. Dr. Cadmus came to Chapel Hill in 1950 as Director of the North Carolina Memorial Hospital and as Professor of Hospital Administration following administrative assignments at the University Hospitals in Cleveland, Ohio, and at the Columbia-Presbyterian Medical Center in New York. When he arrived the hospital was nothing more than a huge mud hole from which a few tentacles of steel were beginning to inch skyward. Following the hospital's activation in 1952, he remained as its Director through its first critical decade of service to North Carolina. He continues to be close to hospital affairs and serves as its Consulting Director.

The Department of Hospital Administration, as do all academic programs, has three broad responsibilities—education, research and service. Through the years, Dr. Cadmus has participated, usually on a limited one or two session basis, in the educational programs of most of the schools within the Division of Health Affairs as well as in such programs as Physical Therapy and Recreational Therapy. These interdisciplinary contacts will hopefully continue and perhaps expand.

Of special interest to the department is the educational impact it might make on medical students. Actually there is no intention to develop a new course and try to squeeze it into the already tight curriculum. Rather, it is hoped that the necessary understanding of how physicians relate to today's modern hospital and the development of healthy attitudes towards this relationship may come from other educational approaches, primarily in cooperation with clinical teaching.

No special school of hospital administration, similar to those already widely established throughout the country, is contemplated. Rather, a cooperative program is being developed with the School of Businses Administration whereby administrative students wishing careers in hospital administration may take

certain special courses offered by the Department of Hospital Administration probably with assistance from other departments or health affairs schools, much as students wishing to specialize in insurance, marketing or personnel concentrate in these fields. The basic educational core, consequently, will be in business administration for which he would receive an unqualified M.B.A. degree. All but two of the present hospital administration programs offer a master's degree in hospital administration, public health or in some similar field, a degree which has limited acceptability should the student wish to shift to commercial career at a later date. As one member of the business faculty put it the other day, "Hospitals are a growth industry, and consequently, we want to have a part in it." As one would expect, opinions vary widely as to the best method of selecting and preparing hospital administrators. Of the five new programs, either under way or in the planning stage, within the southeast, all have different academic foundations. Dr. Cadmus, having served for some years as the Chairman of the Educational Policies Board of the American College of Hospital Administrators, is familiar with these various educational approaches. The U.N.C. plan, which will attempt to preserve that which is sound and reject that which appears undesirable, will be an experiment in graduate hospital administration education worthy of watching. At present, no starting date for this program has been determined.

In respect to research, the Department is currently involved in an N.I.H. financed project entitled "Improving Hospital-Physician Relations Through Education." This is a study of the understanding of hospital-physician relations of students in three schools of medicine—Columbia, Iowa and U.N.C. Certain educational efforts have been directed to the third year U.N.C. students and follow-up studies will reveal if better understanding in this small, but vital phase of a student's education can actually be accomplished.

The most unique and promising function of this new department will be its service to the many community hospitals in North Carolina. In a modest way it would hope to serve hospitals much the same way as the Institute of Government serves government. In general, the department will concentrate on those broad facets of hospital operation concerned with patient care rather than on the pure business or fiscal functions for which there are already available ample recourses should help be needed. Primarily, this will involve the preparation of long range planning surveys, the conducting of hospital care or medical audits, assistance with hospital accreditation, trustee orientation and attention to a wide variety of other operational problems. The services of the department, within the availability of time and staff, will be provided only upon invitation. Most services will be without charge although in those projects requiring a considerable amount of travel and the production of a complex report, minimal charges will be made to cover out-of-pocket expenses for which there are no departmental funds. Already hospitals in such places as Fayetteville, Mount Airy, Thomasville, Mooresville, Siler City, Sparta and Wilson have requested assistance in one form or another from this department. It is also assisting the North Carolina Medical Care Commission in revising the North Carolina hospital licensing regulations.

The department, of course, is still small and is financed from a patchwork of state, grant and trust fund monies. Assisting Dr. Cadmus is Col. Harvey E.

Departmental Conference—Left to right: Rachael Long; Dr. Robert L. Glass; Dr. Robert R. Cadmus, Chairman; Harvey E. Archer; Rachel Forbes.

Archer, who has not only a degree in education from George Washington, but also a masters degree in hospital administration from Baylor University. He recently retired from military service after twenty-seven years with the Army Medical Service. He formerly served as Executive officer at Womack General Hospital at Fort Bragg and most recently was assigned to the Surgeon General's office as Chief of the Hospital Engineering Management Section which is concerned with research and development in all phases of hospital operation. In addition to his military experience, he has maintained a continuing association with civilian health services.

Dr. Robert Lee Glass, a retired neurosurgeon, formerly Chief of Neurosurgery at Indiana University and more recently in private practice in Indianapolis, serves half-time, particularly involved with the research program and with review of medical records. Miss Rachael Long, associated with the North Carolina Memorial Hospital since its very beginning in areas of Personnel and more recently with long range planning, serves as a Research Associate. Miss Rachel Forbes serves as secretary completing the staff of five housed within the new department. In addition, Mr. Crawford, the Director of the North Carolina Memorial Hospital and Messrs. Warden and Lane, the two assistants, hold appointments in this department. Various hospital department heads will assist in special projects and, therefore, become actively engaged in the department's activities. Mr. Arthur Tuttle, the University Planning Officer, also assists the group as its architectural staff member.

The department is currently housed in converted space in the sub-basement of the Interns building. But don't be misled—a quick visit will reveal a light, airy, above ground suite, attractively decorated and well equipped—but like the rest of the School of Medicine, already overcrowded.

OB-GYN Fund Established

Dr. Samuel L. Parker ('40), Clinical Assistant Professor of Obstetrics and Gynecology, has recently made a noteworthy contribution to the Medical Foundation with funds designated for use by the Department of Obstetrics and Gynecology. Additional contributions by his professional associate, Dr. Fleming Fuller, Clinical Associate Professor, and members of the full-time staff of obstetrics and gynecology, have assured a healthy beginning for a developmental fund for this department.

Dr. Parker received his M.D. degree from George Washington University and his residency training at Watts Hospital and Duke University Hospital. He married Frances Carr of Durham and practices his specialty in Kinston, North Carolina, being associated with Doctors Fuller and Tom Vestal (H.S. '54-'58). It is hoped that this will afford an opportunity to persons desiring to contribute to the Ob-Gyn Development Fund.

The Rehabilitation Team

by Donald D. Weir, M.D.*

REHABILITATION IS A TERM applied with increasing frequency. It has come to have many definitions and shades of meaning. Usually implied is some sort of restorative process through which an afflicted individual achieves a better state. Rehabilitation of prisoners, alcoholics, mentally ill, cardiacs, and hemiplegics evokes rather dissimilar associations. The term has become somewhat overworked. Like the flag and motherhood, it is "good," and nearly everyone is in favor of it.

In a medical context, there is, of course, nothing new in the concept of restoring people. This is a major objective in much that physicians traditionally do. There are, however, many chronically ill and disabled people who are not restored to normality by medical and surgical care and who may be subject to further deterioration and increasing disability.

Problems associated with severe physical disability are frequently complex and multifaceted. To deal effectively with these problems, the skills of many different professional specialists may be required. In this context, the concept of *team* care becomes important. In a medical setting, medical specialists, nurses, social workers, physical therapists, occupational therapists, speech therapists, chaplains, brace and limb makers, vocational counselors, psychologists and sundry others may all have contributions to make to the care of the same patients. For a patient, much diversified activity may be involved. If this activity is divergently directed, an effect like Brownian movement may result, with much moving about but little forward progress. Adequate communications between all concerned and coordination of this variegated activity is crucial if the patient is really to benefit.

Chronic illness and physical disability present problems of long duration. Frequently, many aspects of living are affected for the individual, his family, and the community, especially the collective pocketbook. The problems are not medical alone and not all the problems are currently soluble. However, many are not as insoluble and hopeless as is commonly thought.

There are increasing numbers of chronically ill and disabled people, especially in older age groups. Pressures increase to find improved ways of caring for such people in a reasonably comprehensive and efficient manner and as economically as possible.

It has been demonstrated that rehabilitative programs for physically disabled people often justify their cost through the reduction of long-term dependency and the costs of custodial care at home or in institutions. A comprehensive program, involving intensive services of a multiprofessional team, frequently can achieve much in helping restore disabled people. As applied in specialized centers, intensive rehabilitative care may be expensive and utilize much professional time. Economic considerations and shortages of specially trained nurses, therapists, social workers, etc., make some other approach necessary if larger numbers of physically disabled people are to be benefited.

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* Dr. Weir is Assistant Professor of Medicine and Preventive Medicine and Rehabilitation Coordinator, U.N.C. School of Medicine.

The Program at Carolina

At the U.N.C. School of Medicine, the rehabilitation program has been formulated as one which is applicable to numbers of patients, does not unduly prolong hospitalization and carries over to the homes and communities of the patients.

The Rehabilitation Team includes in addition to the author, many other specialized personnel. Miss Ruth Holmes, Rehabilitation Nurse, has had several years' experience in public health nursing prior to her current activities. Miss Elinor Dorries, Home Health Supervisor, serves as liaison between the hospital and the local county and district health departments and public health nurses. She is a well-trained public health nurse. Miss Virginia Rigsbee, Chief Rehabilitation Social Worker, has had extensive experience in public welfare as well as medical social work. Other social workers in the department under the direction of Miss Euzelia Smart, work closely with the Rehabilitation Team in their work with specific patients. Mrs. Betty Cogswell serves with the group as a sociologist and is also a trained vocational counselor. Mrs. Sara Weaver functions as a physical therapist with the Rehabilitation Team in the Outpatient Department. The entire staff in Physical Therapy under Miss Margaret Moore and Miss Sue Flowers function closely with the group in the care of patients. Miss Florence Bearden, Mrs. Ann Smith, and other Occupational Therapy staff members also work extensively with the rehabilitation group. Mr. Joe Ferguson and his staff in the Brace Shop, the staff in Speech Therapy, and in Psychology also frequently work with the group.

The Rehabilitation Team functions in a coordinating and consultative capacity in the care of appropriate patients. Inpatients are not transferred to a separate rehabilitation service but remain with the clinical service to which their disease or injury assigns them. Approximately 15% of patients in medicine, surgery, and pediatrics have complex problems related to physical disability and are known to the rehabilitation group.

Patients are evaluated not only in terms of disease or injury but also in terms of specific disability and residual function or ability. Associated psychological and social problems are also assessed. Patients are both private and staff, and of diverse ages, social backgrounds and vocational categories. They present a variety of physical disabilities. Arthritic disorders and collagen diseases are commonly represented because of the author's special interests. Hemiplegia, spinal cord disorders, peripheral neuritis, and other chronic disabling conditions are commonly included.

Rounds by the rehabilitation group are conducted as team conferences. The social worker, physical therapist, and occupational therapist treating the specific patient under discussion attend together with other rehabilitation personnel, house officers, ward nurses, and assorted students. Goals for achievement during hospitalization and plans for long-term care after discharge are reviewed.

Functions of the Team

Rehabilitation is conceived by the team as a process which a disabled individual himself must accomplish. Emotional adjustment and motivation to improve are of great importance. Rehabilitation is not accomplished within institutions, especially general hospitals, except in a limited sense. It must be translated into living at home and in a community. The role of the family is

The Rehabilitation group evaluating an arthritic patient. From the left are Dr. Weir; Florence Bearden, O.T.; Virginia Rigsbee, Social Service; Ruth Holmes, Rehabilitation Nurse; Ann Smith, O.T.; Sara Weaver, P.T.; Sandra Allen, Secretary; and Sue Harper, P.T.

of great importance. In most cases, relatives will be involved in long-term care at home. If family members consider the patient a hopeless invalid, he likely will tend to become this, even if he had potential to accomplish much more. Positive family, as well as patient, attitudes are most helpful. An additional factor is duration of disability. If the educational, counseling and therapeutic activities designed to promote rehabilitation are begun early, the results are much more favorable. If the patient and his family have become accustomed to invalidism, often nothing will be accomplished.

One of the objectives in rehabilitative patient care is the reduction of dependency. This includes both physical dependency so that the disabled individual cares for himself as completely as possible, and socioeconomic dependency, so that the family can remain as self-sufficient, economically and otherwise, as possible.

Toward the objective of reducing physical dependency, nursing, physical therapy, and occupational therapy are of major help. In rehabilitation, the emphasis in nursing shifts from doing things for the patient to encouraging and teaching the patient to do for himself. Thus, the hemiplegic stroke victim can quickly learn to feed, bathe and dress himself using his good arm.

Physical therapy employs various physical modalities therapeutically such as heat, diathermy or ultrasound. More important, however, are therapeutic exercises to improve motion, strength, and coordination. Training in the use

of aids such as braces, crutches, and wheel chairs independently is also given by the physical therapists.

Occupational therapy employs various manual creative activities for therapeutic purposes. A craft project may thus be set up in a specific way to achieve repetitive exercise of a disabled part to improve strength or motion. The occupational therapists also assist in training disabled people in various aspects of self care. This frequently includes use of assistive devices. A sharp rounded "rocking" knife may enable a one-handed person to cut his meat independently. Various holding devices may make activities such as cleaning glasses or cutting fingernails, one-handed operations. Long or thick-handled utensils may enable specific patients to perform various activities independently. Occupational therapists often can help retrain disabled homemakers in simplified methods for performing various household tasks. They frequently can also help explore possible future vocational objectives for disabled people.

In many instances patients and relatives also need assistance with an enormous array of psychological and social problems related to physical disability. Often resolution or at least palliation of such problems is crucial to the successful implementation of a long-term home program and any real rehabilitation. Psychiatric care is occasionally required. Frequently, social case work is especially helpful in successfully dealing with such problems. The social workers also are of considerable help through their knowledge of various community resources which may be of assistance to the patient.

Home Care

Despite improved physical function and self-care observed in the hospital, for most patients, the program must be continued at home to be really successful. Families frequently do an excellent job in caring for even the most severely disabled, if they are carefully instructed in the techniques and procedures involved and are periodically supervised. Considerable time and effort is spent by the rehabilitation group in expediting the transfer of programs of care from hospital to home. Teaching the details of diet, medication, appropriate nursing care, self-care activities, use of assistive devices and special equipment, home physical therapy, and occupational therapy programs is time consuming.

Communications to various local personnel are of considerable importance. Patients and families may need further supervision and assistance. Often information and instructions, which seemed perfectly clear in the hospital, become a sea of confusion at home, even with written instructions for reference. The local personal physician, obviously, has a key role in the continued care at home and needs to be informed and involved in all facets of the program.

Public health nurses in the local health department are frequently requested, as part of this program, to make home visits on patients discharged from the hospital. The nurses are supplied with specific details of the program and instructions given the patient and family. The public health nurse, after clearing with the personal physician, visits the patient and family periodically. The home nursing care, diet, medications, home physical and occupational therapy programs are reviewed and reinforced. The nurse often spots problems which need further attention. The written reports from the public health nurses are of considerable help to hospital personnel. Home evaluations prior to discharge from the hospital enable more realistic plans for home care to be de-

veloped. The followup reports after discharge indicate areas of progress and sources of difficulty.

A home program must be realistic. It accomplishes little to prescribe daily hot packs for an arthritic patient who must chop wood to build a fire and carry water from the well to prepare the hot packs. It profits little to instruct the brother of a hemiplegic patient how to assist with exercises, when the brother absents himself frequently for days or weeks on alcoholic sprees. Anticipating and planning for such problems is facilitated by the public health nurse's reports, supplementing data gathered at the hospital.

The public health nurses are not able to render bedside nursing care. However, the limited supervision of the care given by the family is most valuable. This service has, in this program, been well received by private as well as staff patients. Usually, physicians, who understand the nature and purpose of this activity, find the information and observations the nurses can provide of considerable help in their continued care of chronically ill and disabled patients.

The N.C. State Board of Health employs several physical therapists for the various crippled children's clinics and as part of the chronic disease program. These therapists cooperate with our program by visiting at home selected patients discharged from the hospital, at approximately monthly intervals. Usually, the therapist is accompanied by the local public health nurse. The home physical therapy program is reviewed and, with permission of the physician, can be upgraded as the patient improves. The nurse can then review this with the patient between visits by the therapist. In some communities physical therapists are available in local hospitals, private practice, or employed by the health department or other groups. In these areas more intensive physical therapy supervision can be obtained in the home programs of certain patients.

The local welfare department often is of help, not only with financial problems, but also with at least limited case work services. Public financial assistance is obviously not a goal in itself. It may be of value temporarily, until more adequate rehabilitation can be achieved to thereby reduce the problem of long-term social disability. Homemaker services, offered in some counties, are of immense aid in some difficult family situations. Certain patients are already known to the local welfare department. In these cases, information from the case workers can be of great help in planning for long-term care.

Various other local organizations may be of assistance in individual cases. Church groups, civic clubs, the Society for Crippled Children and Adults, and other groups may be called upon. For patients with potential for return to gainful employment, the State Vocational Rehabilitation program offers diverse forms of assistance to help disabled people return to work.

The most common limiting factor in restoration vocationally is not physical disability but lack of education and skills which can be used productively despite disability. There are few employment opportunities for the functionally illiterate and unskilled with disability. More adult educational opportunities and sheltered workshops would certainly help reduce the number of disabled people who currently remain "on the welfare."

Outpatient Program

A number of chronically ill and disabled patients are followed periodically as outpatients in the Chronic Disease and Rehabilitation Clinic. Patients are ad-

mitted to this clinic primarily on the basis of need for continued, coordinated, multiprofessional or team care. Most patients can be adequately cared for by their own physician and are returned to him. Some patients with more complex problems have continued needs for special nursing care, physical therapy, occupational therapy, case work, and other services if further improvement is to be obtained.

In the Chronic Disease and Rehabilitation Clinic attention is given primarily to long-range home care. Periodic assessment of disability and associated psychosocial problems and the implementation of a comprehensive but realistic home program are emphasized. With outpatients, the home care program, if complex, may be developed gradually over several clinic visits. Psychological and social problems also are resolved or palliated only gradually.

For patients and their families learning what to do in home care may not be too difficult. Actually, carrying out programs, repetitively and consistently for prolonged periods of time, is a quite different matter. Periodic reinforcement and encouragement are of great importance. The personal physician, local public health nurses, visiting therapists, and other community resources are important in long-range care of outpatients in a manner quite analogous with the inpatient program.

There is much about care of severely disabled people which is not as scientifically based as in other branches of therapeutics. Many complex variables are involved especially human variables which defy ready quantification and measurement. "Tincture of enthusiasm" and the "art of medicine" clearly are of importance and may be more so than specific forms of therapy. The difference between a rehabilitated paraplegic and one who is a complete invalid lies in a little "know how," consistently applied, and a favorable state of mind. Rheumatoid arthritis is a disease for which only more or less palliative therapy is available. Control and limitation of potential disability is a long-term goal viewed over decades. To accept and live with the disease with equanimity, while carrying out, over and over, a routine program of exercises, splints and medications is difficult. These items do make considerable difference in limiting the eventual degree of disability and the degree to which the afflicted person regresses to a whining, complaining invalid. The care of a hemiplegic individual is not as great a problem if the person learns to walk and independently care for himself. By contrast, many hemiplegics, without some rehabilitative efforts, undoubtedly would remain in bed, incontinent, and completely helpless, letting others care for them.

With many physically disabled patients, goals are limited and are attained only slowly. The alternative to a program aimed at some degree of rehabilitation is, for many patients, further physical deterioration and psychological invalidism with very difficult problems of long-term care for the families involved.

For some patients, one criterion of limited success in rehabilitation is merely avoiding rehospitalization with various complicating problems. Many patients are able to achieve much more. In some cases other family members may be freed from caring for the patient, who has learned to care for himself, and can seek outside employment. Certain patients, unfortunately, too few at present, are able to seek employment themselves and resume a productive role in family and community affairs.

presenting... The Alumni

DR. HARRY L. BROCKMANN

Dr. Harry L. Brockmann of High Point, president of the UNC Medical Alumni Association, is currently beginning the forty-first year of his surgical practice and the seventy-second year of a fruitful varied life that has brought him the honor of his peers.

A two-year man at the UNC medical school, Dr. Brockmann received his M.D. at the University of Pennsylvania. From 1917 to 1920 he was a lieutenant in the Medical Corps of the U. S. Navy, engaged with "ten or twelve" other officers in establishing medical care for inhabitants of the Virgin Islands, purchased by the U. S. from Denmark in 1916. His work involved surgery and tropical medicine and he had personal responsibility for a leper colony, an insane asylum and a hospital for, as he says, "the lame, the halt, and the blind." Working on St. Croix, he was also an associate in surgery and medical treatment to a general hospital.

After the war service, he returned to do graduate work at the Hospital of the University of Pennsylvania, and then began his surgical practice in High Point.

One of Dr. Brockmann's main concerns has been the encouragement of mutually cooperative practice among the M.D.s of his home city. He was for years a member of the Burrus Clinic Group and later was actively involved in developing the present High Point Medical Center.

He has also worked to increase coordination of effort between hospital administrators and the nursing and medical professions. For twenty-five years he has taught anatomy and physiology to students in nursing school.

Dr. Brockmann is former president of the North Carolina Hospital Association, has been a member and chairman of the Committee on Nursing of the state Medical Society and has served on a joint committee to have laws enacted for licensing practical nurses in North Carolina. These activities, and his membership on the board of directors of the North Carolina Hospital Saving Association, express his efforts for improved patient care.

A former president of the Guilford County Medical Society and of the Eighth District (N.C.) Medical Society, Dr. Brockmann has also served as councilor to both the Southeastern Surgical Congress and the Southern Medical Association.

(Continued on page 27)

presenting... The Faculty

DR. EDWARD GLASSMAN

Dr. Edward Glassman was appointed to the faculty of the School of Medicine in July 1960 as Assistant Professor of Biochemistry, and in September 1961 he was awarded a Senior Research Fellowship* by the Public Health Service for a five-year period.

Dr. Glassman received B.A. and M.S. degrees from New York University and the Ph.D. degree from The Johns Hopkins University in 1955. He was Postdoctoral Fellow of the American Cancer Society at California Institute of Technology from 1955 to 1957; Research Associate at City of Hope Medical Center, 1957-1958; and Postdoctoral Fellow of the Public Health Service at the University of Edinburgh from 1958 to 1959. Thereafter, he returned to City of Hope Medical Center for one year before joining the faculty of our School of Medicine.

Dr. Glassman has broad research interests in biochemical genetics, but his research is directed principally toward a study of the genetic control of xanthine dehydrogenase in Drosophila. This research has led to the important discovery of an *in vitro* complementation between nonallelic mutants deficient in the enzyme, xanthine dehydrogenase. This significant observation provides an important "breakthrough" in the study of genetic control of enzyme synthesis, and it has broad implications for a more detailed study of so-called "inborn errors" of metabolism in human beings.

* The Public Health Service has redesignated these fellowships as Career Development Awards.

Presenting the House Staff

DR. CARL BLACKBURN LYLE, JR.

Dr. Lyle, a native of Tennessee, is Chief Resident in Medicine. He received his undergraduate education at Princeton University and was awarded his medical degree by the Columbia College of Physicians and Surgeons in 1957. He served his internship at the University of California Hospitals in San Francisco, California and then returned to the South to take his junior residency at Duke University Hospital. In 1959 he entered the United States Air Force and was for two years an instructor in Aviation Medicine and was engaged in Aerospace-medical research at the Aerospace Medical Center at Brooks Air Force Base in San Antonio, Texas. He came to Chapel Hill as a senior resident in 1961 and took over his present assignment in July of this year. His research interests have included studies in neurogenic aspects of pulmonary edema, cerebral embolic phenomenon, fat embolization, decompression sickness, syncope and sickle cell anemia.

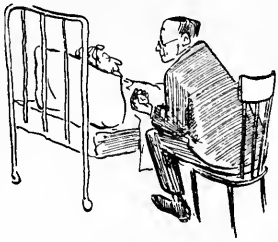
He is married to the former Ishbel McGill Keefer of Boston and they have one son. Dr. Lyle is interested in group practice and plans to remain in North Carolina.

Dr. Brockmann—(continued)

He is a life elder in the Presbyterian Church and plays the piano "to the extent of being assistant pianist for the men's Bible class." He is currently, and has for years been, a member of the High Point Chamber of Commerce's Congressional Action Committee, and has 39 years of activity in the local Civitan Club. He is a former member of the Guilford County Board of Health and the Board of Welfare, a former director of the local and state Tuberculosis Association, and a member of Emerywood Country Club.

His recreational activities have gone from tennis to golf to gardening and fishing, and he has a great reader's interest in economics and political science.

He and Mrs. Brockmann have two sons, both teachers: one a surgeon and the other a Christian minister.



ALUMNI NEWS ITEMS

CLASS OF 1924

Ed. Note: In the brief biographical sketch of Dr. John W. Ormand, Sr., '24, P. O. Box 397, Monroe, North Carolina, which appeared in Alumni News Items, October, 1962, mention was inadvertently omitted of the fact that Dr. Ormand's two sons, John W., Jr. and Thomas Lane, are both graduates of the U.N.C. School of Medicine. John W., Jr. was a member of the class of 1956 and Thomas Lane of the class of 1958.

CLASS OF 1945

GEORGE WALKER BLAIR, JR., 328 West Davis Street, Burlington, N. C. Associated with another internist, he practices internal medicine. Had his last two years of Medical School at the University of Pennsylvania (AOA) and internship and residency at the hospital of the University of Pennsylvania. He served as Chief of Staff at Alamance General Hospital, Burlington, N. C., from January, '56, until the hospital was transferred to its new building and became Memorial Hospital of Alamance County in December, 1961. He served as Chief of Staff of Memorial Hospital of Alamance County from December, 1961 until October, 1962. He married the former Sara Jo Barnett and they have three children: George Walker, III, 10, Barnett Lipscomb, 7, and Sara Wilhite, 3.

KIRBY T. HART, JR., 109 S. Market St., Petersburg, Virginia. Does Pediatrics in partnership with two other pediatricians. Had his postgraduate training at Boston City Hospital, University Hospital, Cleveland, and MCVA—Richmond Hospital. He holds membership in the American Academy of Pediatrics and is a diplomate of the American Board of Pediatrics. He and his wife, George Anne, have one son, Kirby, III, 11. A deacon in the Second Presbyterian Church and a member of Rotary, golf and travel are his principal recreational interests.

RICHARD E. HOOKS, 123 N. 2nd Street, St. Pauls, N. C. Does general practice. Postgraduate training was done at James Walker Memorial Hospital in Wilmington, N. C. He and his wife, Anne, have one son, age 15. He is Assistant Chief of Staff, Robeson County Memorial Hospital, a member of the Town Board of Commissioners, and a deacon of the First Baptist Church in St. Pauls. For recreation, he fishes and water skis at White Lake.

JOE H. MONROE, 415 N. Spring Street, Winston-Salem, N. C. Practices Obstetrics and Gynecology. A diplomate in Ob-Gyn, he had postgraduate training at University of Cincinnati and Yale Medical Centers. He and his wife, the former Elizabeth Breeden,

have three children: Elizabeth Cloud, 12, Joe, Jr., 10, and Thomas Guy III, 4. His recreational activities include cabinet making and fishing (rarely).

CLASS OF 1946

DAVID Y. COOPER, 424 Colebrook Lane, Bryn Mawr, Pa. Does research surgery. Postgraduate training was obtained at the University of Pennsylvania. He and his wife, Cynthia, have two children: Lucy and Allison.

LUTHER W. KELLY, JR., Nalle Clinic, 1350 S. Kings Drive, Charlotte 7, N. C. Does internal medicine (endocrinology). A fellow of the American College of Physicians, he did postgraduate work at Harvard and at University Hospitals, Cleveland, Ohio. He is married to the former Susan Bowman and they have two children: Abbott Bowman, 5, and Mary Luther, 4. A past president of the Unitarian Church, of the Family and Children's Service, and the Council on Human Relations, he is a member of the Social Planning Council and has been honored with the W.S.O.C. Public Service Achievement Award. He is a member of the Charlotte Country Club and the Charlotte Badminton Club and enjoys playing golf.

WILLIAM E. SHEELY, 509 Cathedral Drive, Alexandria, Va. Does radiology in partnership with two other radiologists. Postgraduate training was received at Philadelphia General Hospital. Now Chairman-elect of the Section on Radiology of the D. C. Medical Society, he served as secretary for the last three years. He and his wife, Amelia, have three children, Mary Ellen, 11, Elizabeth Ann, 6, and Susan Virginia, 4. Favorite recreational activity: golf (for the exercise!!). Of trips taken, he reports that only short trips have been taken so far to meetings in the U.S. "till the kids get older."

EDWIN L. WEBB, 634 East Patton Ave., Montgomery 5, Alabama. Has practice in pediatrics and pediatric allergy. Did his postgraduate work at Louisville Children's Hospital and University of Louisville, Louisville, Kentucky. A fellow of the American Academy of Pediatrics, he is a diplomate of the American Board of Pediatrics. He married the former Francis Brice (U.N.C. '45) and they have three children: Elise, 13, Lee, 10, and Janet, 7. An elder in the Westminster Presbyterian Church, he received the Boy Scout Award for Distinguished and Outstanding Service for 1962. Chief recreational interests are numismatics, golf, and photography. Interesting trips taken: Eastern Canada—'59; Mexico—'60; Western Canada—'61; International Congress of Pediatrics—Lisbon and Western Europe—'62 (for one month).

CLASS OF 1947

WILLIAM H. BLAND, Cary, N. C. Does private general practice, solo. Postgraduate training was received at Rex Hospital in Raleigh. He married the former Jane Hobgood and they are the parents of three children: William Herbert, Jr., 12; Frank Hobgood, 11; and James Robert, 10. A member of Cary Methodist Church, he teaches the Young Adult Class. Among his recreational activities are golf and softball and he had an interesting trip to Hawaii in '61.

W. ERNEST POWELL, JR., Mountainview Rd., Mars Hill, N. C. Does general practice in partnership with two other physicians. A member of AOA, he did his postgraduate work at Duke. He and his wife, Frances, have three children: Billy, 9; Carol, 7; and Allen, 1. For recreation he enjoys fishing.

HEWITT ROSE, 2009 Clark Ave., Raleigh. A surgeon, with boards in general and thoracic surgery, his postgraduate training was received at the Medical College of Virginia, University of Alabama Medical School Hospital, and Washington University in St. Louis. Married to the former Dudley Hill, he and Dudley have two sons: Hewitt III, 11, and Dudley, 9. A Presbyterian, he is a member of the White Memorial Presbyterian Church.

EMILY TUFTS, 660 S. W. Broad Street, Southern Pines, N. C. Does a solo pediatric practice. Now on the clinical staff at N. C. Memorial Hospital, Chapel Hill, she did her postgraduate work at St. Christopher's Hospital for Children in Philadelphia. She is active in work with the Red Cross and with retarded and crippled children. She had an interesting trip to Europe in 1960. Was in the earthquake in Yellowstone in 1959.

SHERROD NEWBERRY WOOD, Enfield, N. C. Does general practice, solo. His internship was done at U.S. Naval Hospital in Portsmouth, Va. (1950-51). He married the former Hulda Turner and they have three children: Amy Lou, 5; Turner, 4; and Valerie, 2. He is secretary-treasurer of the Enfield Recreation Commission and a member of the Enfield Educational Foundation. Hunting and fishing are chief among his recreational activities.

GEORGE ROBERT SMITH, JR., '51, Shawsville, Va. Mildred and Bob just had their fourth child — now have three girls and a boy. Bob continues in general practice in Shawsville, Va., in association with Dr. Clarence Taylor, '58.

CLARENCE TAYLOR, '58, Shawsville, Va. Clarence and Ora now have two boys and a girl. Clarence continues in general practice in Shawsville, Va., in association with Dr. Bob Smith, '51.

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Vol. X FEBRUARY, 1963 No. 3

THE BULLETIN

School of Medicine
University of North Carolina

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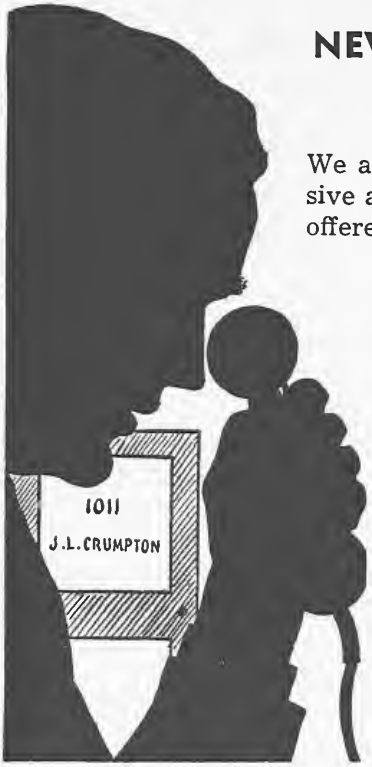

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THE BULLETIN

of the School of Medicine
of the University of North Carolina

Published in cooperation with the Whitehead Medical Society
and the Medical Foundation of North Carolina, Inc.

Vol. X | February, 1963 | No. 3

IN THIS ISSUE

Editorial Committee

Address all inquiries and communications to Emory S. Hunt, 117 Medical Science Building—or Box 957, Chapel Hill, N. C.

Published four times a year — October, December, February and April — Entered as third-class matter at the Post Office at Chapel Hill, N. C.

Continuation Education: An Editorial

In this time, when "the delivery of medical care" is considered primarily in economic terms, it should be recalled that one of the most important considerations concerning this endeavor is the ability of physicians to become and stay educated in medical science. Many of the troublesome aspects of postgraduate medical education were recently examined in a thoughtful and provocative report by a Joint Study Committee.* This group proposed the long range development of a "University without Walls" for postgraduate medical education.

It may be useful to examine briefly some of the measures currently used by physicians in efforts to keep up with advancing medical knowledge. First, there are the problems associated with reading the medical literature: time in which to do so and a measure of selectivity which will best accomplish the purpose. These are really major problems, no doubt of it. It is a difficult task to keep even current journals from simply piling up. Furthermore, the complex character of the literature lends itself in but a limited way to productive perusal. Some physicians try to set aside specific hours of the week for this purpose, but these intentions too often fall victim to the exigencies of the day. The plan to set aside time for this purpose, however, is well worth a most earnest effort. The subject matter can logically be divided into two major categories: general and special. From the systematic reading of several general medical periodicals and one or two special interest journals, one may surprisingly cull much of contemporary interest. The editorials in particular tend to emphasize recent and noteworthy developments. Special reading concerns problems actually encountered and is a particularly vital part of the overall effort. It is in this regard that the hospital or the community medical library can make an important contribution by the provision of up-to-date textbooks, as well as a selection of current periodicals; and here too it is that habits of study and pursuit developed during medical school and residency days assert themselves. It is probably reasonable to consider that earnest, critical and selective reading is the most important form of continuing medical education. The doctor who does not read is not likely to stay educated in his profession very long.

Participation in hospital or community medical rounds, with recourse to the literature or consulting colleagues, is a widely used technique by which the physician shares his experiences with his fellows. Many physicians now take blocks of time away from their practice for study. This time may be well spent in individual efforts or, increasingly, by attendance at organized postgraduate courses. The latter are widely available, are genuine working sessions and often provide a useful didactic stimulus. The scientific sections of organizational meetings vary greatly in quality and usefulness. Too often, however, these meetings combine work with play, the latter all but precluding the former. Such meetings may have very significant value to the physician, both as a pleasant experience and in support of his professional organization; but this often does not constitute a serious educational effort on the part of the attendee. A variety of other techniques are receiving attention, such as two-way radio conferences, tape recorded panels, and correspondence courses. We badly need effective means of evaluating the benefits of each of these approaches.

C.C.F.

* Dryer, B. V., Lifetime Learning for Physicians, J. Med. Educ.—37:1962—part 2.

The Personal Physician

Key Man In Medical Care

By William J. Cromartie, M.D.*

The chief problem in our medical program today is that of supplying a sufficient number of personal physicians: well-trained practitioners capable of bringing the latest developments in medical science into the area of patient care. A personal physician is one who assumes comprehensive and continuing responsibility for the medical care of the individual. In most cases, he will himself handle the medical problems involved, referring the patient to the appropriate specialist for the remainder. The major difficulty we now face is that of providing each of our citizens with such a qualified personal physician.

Much of our resources going into medical programs is given to attempts to compensate for the shortage of personal physicians. Clinics are set up for the diagnosis of cancer, heart disease, diabetes and tuberculosis; immunizations are given on a community-wide scale. Necessary as they may be at this time, such programs are poor substitutes for periodic health reviews; i.e., history, physical examination, and indicated laboratory and x-ray studies, and planned preventive medicine on an individual basis. No program, or series of programs, which deals with only one aspect of medical care can take the place of the personal physician. He is the key figure in any approach to obtaining the benefits of our medical knowledge for every citizen.

---

* Dr. Cromartie is Professor of Bacteriology and Medicine, the University of North Carolina School of Medicine.

Included in the designation of personal physician are three kinds of practitioners: the pediatrician who takes responsibility for the care of children; the internist who is concerned with the care of adults; and the family physician whose practice encompasses all age groups. It should be noted that some pediatricians and internists limit their practice to consultation work, accepting patients only on referral; however, the majority are in practice as personal physicians even though they function partially as consultants in a subspecialty. There is general agreement as to the functions and training of the internist and the pediatrician. It is in defining the scope of the family doctor that we find a great divergence of views among both medical educators and practicing physicians.

Fifty years ago, the family doctor was internist, pediatrician, surgeon, obstetrician, and psychiatrist. Specialists were out of reach, geographically and financially, in most cases. That the life expectancy of the patient was only half of what it is today is no reflection on the abilities and training of the family doctor but only an indication of the progress medical science has made in the past half century.

This increasing body of knowledge which the medical graduate must master makes necessary a reevaluation of the training programs designed to produce personal physicians. It seems obvious that in the future it will be necessary for the personal physician to refer to the specialist certain areas of patient care which have been, and to some extent are still, the province of the family physician. To say that changes are necessary in training personal physicians of the future, however, should not be taken as criticism of different patterns which were appropriate in the past.

Despite many opinions to the contrary, the trend seems to be increasingly away from the practice of surgery by the personal physician. Where formerly it was necessary in many localities that the general practitioner should be trained in surgery, there are few places in the country today which are not within easy reach of competent surgical specialists. With knowledge in every field of medicine multiplying rapidly, it would seem impossible for one practitioner to keep sufficiently abreast of all fields to offer the best possible care to his patients. Minor surgery and the emergency and primary management of trauma will in all probability be a part of the practice of any personal physician, but the time required for surgical training beyond these would better be spent in other fields, leaving surgical problems to the surgical specialist.

What has just been said in reference to surgery applies, in my opinion, to obstetrics and gynecology also, though there is even less agreement among medical practitioners on this subject. The personal physician will need to be well-versed in obstetrical and gynecological diagnosis and in the medical management of problems related to these fields, but beyond this, the personal physician of the future will, when it is possible, refer patients in this area to the well-trained obstetrician and gynecologist.

The medical disciplines most to be emphasized in the training of the family practitioner of the future, then, will be those of internal medicine and pediatrics.* There are medical educators who question the wisdom of trying to educate an individual who will function as both pediatrician and internist. Since it is not possible at this time to determine whether the family of the

* I wish to make it clear that I consider basic training in psychiatry and preventive medicine an integral part of training in internal medicine and pediatrics, and I therefore make no separate mention of these fields.

future will be better off with two personal physicians—an internist and a pediatrician—or with one family physician, most would agree that until this question is answered a concerted effort should be made to increase the numbers of all three types of personal physicians. It should be emphasized that the family physician who treats patients of all ages will need to be as well trained in pediatrics and internal medicine as the personal physician who functions in only one of these fields.

In addition to the question of what type of training the personal physician will need, about which much controversy arises, there is the question of where and how the necessary training will be given. Those who still hold to a concept of general practice in which the personal physician takes responsibility in all fields of medical care tend to feel that rotating internships of one or two years' duration provide the best training for general practice. Others who view the personal physician of the future as a specialist taking responsibility for continuing and comprehensive medical care of the individual feel that he must be as thoroughly trained as any other specialist and that this is not possible in our present rotating internships.

A variety of programs are now being offered whose purpose is to train the family physician as a specialist.* In the North Carolina Memorial Hospital, the mixed internship is divided between duty in the Departments of Medicine and Pediatrics, in which there is active participation by the Department of Psychiatry, and a period of one and a half months in the Emergency Room. This is followed by two years of residency, one each in medicine and pediatrics. An optional third year of residency provides rotation through the subspecialties of medicine and pediatrics or training in obstetrics may be obtained for 6-12 months. There are 184 officially approved residency programs for general practice throughout the country. Their content and duration vary greatly, reflecting the divergent opinions as to the proper training for practice as a personal physician.

Of the general practice residencies mentioned above, 27 are in hospitals affiliated with medical schools, the remaining 156 in a variety of public and private hospitals. In assessing the value of these programs from the point of view of training a medical graduate as a specialist in personal care of the patient, we need to consider how well the hospital can operate as an educational institu-

* Training of the two other types of personal physicians (pediatricians and internists) is not considered in this essay.

tion. A hospital may offer excellent patient care and facilities and still be unable to give the kind of training necessary to produce personal physicians of the quality needed. Such training is expensive. It requires in addition to a staff capable of giving the time needed to teaching interns and residents, the services of a full-time director of education to supervise their training. It requires a patient load large and varied enough so that trainees have a wide experience of different types of medical problems in the course of the training period. It is obvious that a share of the burden of training beyond medical school will be borne by non-affiliated hospitals and there is no reason why this training cannot be of excellent quality provided it is kept in mind that the primary purpose of an internship-residency program is the education of the future practitioner and not the services which are rendered to the hospital by the trainee.

In addition to residencies in general practice, two experimental programs designed to train the graduate for practice as a personal physician have been approved by the AMA House of Delegates. The Family Practice Program consists of two years' training: eighteen months divided between medicine and pediatrics, an optional four months' training in obstetrics and gynecology, and service in the emergency room and outpatient departments. The two-year Program for General Practice is divided into a year of medicine and pediatrics and one of surgery, obstetrics and gynecology.

The first of these was the result of a Report on Preparation for Family Practice made by a committee composed of representatives of the Council on Medical Education and Hospitals, The Association of American Medical Colleges, and the American Academy of General Practice. It was emphasized that the report was concerned entirely with the preparation of physicians in the *future* for family practice, and was not to be interpreted as having import for the training or privileges of general practitioners now in practice. Nevertheless, there was some alarm that the philosophy expressed in the committee report might be used as an excuse to restrict the hospital privileges of general practitioners and resolutions were passed by the House of Delegates asking the Council on Medical Education and Hospitals to consider for approval other two-year programs which would incorporate experience in obstetrics and surgery. The programs now designated as General Practice Programs are the result of this action.

One of the great difficulties in establishing new programs to fit changing patterns of medical practice is that too often a new approach is taken as criticism of programs of the past. The resistance of many general practitioners to the views expressed in the report of the Committee on Preparation for Family Practice and to General Practice Residency programs like the one at North Carolina Memorial Hospital increases the difficulty of attracting medical students into training as personal physicians. The acrimonious debate and conflicting advice tend to keep medical graduates out of those programs where they are most needed. Until greater agreement can be reached as to the future role of the personal physician and the training therefor, there can be little hope of attracting the necessary personnel into these programs.

Several years ago, a British physician,* concerned with some of the same problems discussed here, stated: "Whereas until recently our tendency on graduation day was to select the future specialists and let everybody else go into general practice, we might do better in the future to select the future

personal doctors and let everybody else be a specialist." If this could be done, I believe it would help greatly in solving the problem of recruiting medical graduates into practice as personal physicians. For the first-rate student is not looking for a program that is quick or easy, but for one which will offer a challenge to his abilities. The sooner it can be recognized, among medical educators and others in the profession and by the public, that to be a truly excellent personal physician requires as much, if not more, ability than to be a first-rate specialist, the sooner we will begin to encourage our best scholars to choose this branch of medicine.

At the same time, we must realize that a longer time is needed for training in this field, and a way must be found to provide adequate compensation during the residency period. If, in addition to a real challenge and adequate compensation, we are able to offer recognition to those choosing such careers, preferably through existing specialty boards or by a less favorable alternative, establishing a specialty board of family practice, we would be a long way toward solving the problem of securing a sufficient number of students for family practice programs.

One further point needs to be mentioned briefly. Even if agreement can be reached on methods of training, and problems of recruitment solved, we will still have to educate the public. Our citizenry should be taught to recognize sound programs of medical care, to use them intelligently, and to provide the community atmosphere necessary to their establishment and growth.

No problem in medical care is more important than securing adequate numbers of highly trained personal physicians, and none so beset with difficulties. We must begin with the recognition that the area of personal physician is an important specialty and that it will differ in the future from the general practice of the past. We must formulate programs which take this into account and establish methods of training as challenging and demanding as are now offered in recognized specialties. By showing the medical graduate the difficulty and importance of such training and giving recognition to those who choose this field, we must attract more of our finest students into it. Only then can we bring to the individual patient the benefits of the great advancements in medical knowledge.

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* Fox, T. F., *The Personal Doctor:* Lancet, April 2, 1960, pp. 743-760.

IN MEMORIAM

During the summer, Mr. and Mrs. W. J. Porter of Burlington, N. C. were notified officially by telegram from the Navy Department of the loss of their son, Lt. Richard A. Porter, '59, who was a Naval Medical officer based at Macon, Georgia. Lt. Porter and Air Force Captain Frank Schilling of Phoenix, Arizona, lost their lives while skin-diving at Blue Springs Caverns near Madison, Florida.

Following his graduation from the Medical School in 1959, Lt. Porter served an internship at the General Rose Memorial Hospital in Denver, Colorado. He was nearing the completion of two years of active duty with the Navy and had accepted a position with a clinic in Banning, California.

Surviving in addition to his parents are his wife, Mrs. Nillah Gilbert Porter, two daughters, Deborah Lynn and Christine Rose; one sister, Barbara Joan Porter, and his grandfather, O. M. Ingebretson.

The Intensive Care Unit

N. C. Memorial Hospital

By Miss Ethel F. Harrison*

The concept of an Intensive Care Unit for the care of the acutely ill patient is not new to the North Carolina Memorial Hospital. As early as the summer of 1953, representatives of the medical staff, administration, and the nursing staff of the hospital recognized the need to locate the acutely and seriously ill in one area in order to provide closer observation and a greater concentration of nursing care than was possible in the usual patient unit. Accordingly, two adjoining four bed wards were modified for this purpose and were opened as a "Special Care" unit. While maintaining the essential elements of an Intensive Care unit and thus serving a very useful purpose for a number of years, this area was limited by its size and lack of facilities for isolation or quiet.

Dreams of a bigger and better unit, tailored to fit the needs of the patients of the North Carolina Memorial Hospital, were finally realized when funds were donated by the University, the Hospital Women's Auxiliary, and the federal Hill-Burton program through the North Carolina Medical Care Commission. This made it possible to design, construct, and equip an area in the east wing of the hospital for this purpose.

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* Miss Harrison is a graduate of Duke University (B.S.N.) and Columbia University (M.A. 1951). She has been Supervisor and Assistant Director of the Nursing Service at N. C. Memorial Hospital since 1952 and has been a key person in the organization and development of the Intensive Care Unit.

The new Intensive Care Unit was activated in April of 1962 and can currently care for 16 to 18 patients. Patients are admitted to this unit in accordance with their medical and nursing needs regardless of their age, sex, race, or the nature of their illness.

There is a nurses' station with routine and emergency supplies, equipment, and drugs for each six beds. Although seemingly costly in the beginning, the provision of these items at each station pays large dividends in patient care by saving vital seconds in emergencies and countless time and steps in daily care.

Each bed space is equipped with oxygen, suction, vacuum control manometer, wall mounted sphygmomanometer, intravenous standard, special overhead and wall mounted lighting, and additional electrical outlets.

Glazed partitions and doors have been effectively used to provide the maximum possible observation of patients while permitting flexibility in arrangement of patients regardless of diagnosis or condition. Privacy and quiet may be achieved by the simple act of pulling shades installed at each glazed partition and closing the cubicle door. An additional advantage of this construction is the security given patients by their ability to see their doctor and/or nurse from their bed.

An intercom at each nurses' station provides means of immediate communication with personnel in all stations in the event of an emergency as well as saving time in routine transactions.

One of the three patient areas in the unit is especially designed and fitted for isolation, having foot controlled sinks in each room and a ventilating system which provides exhaust under positive pressure. This area is chosen for the care and treatment of acute burns but may be used for any other acutely or seriously ill patient when not occupied by the former. Special equipment has been added to the basic treatment room facilities on the unit to aid in the treatment and care of severe burns.

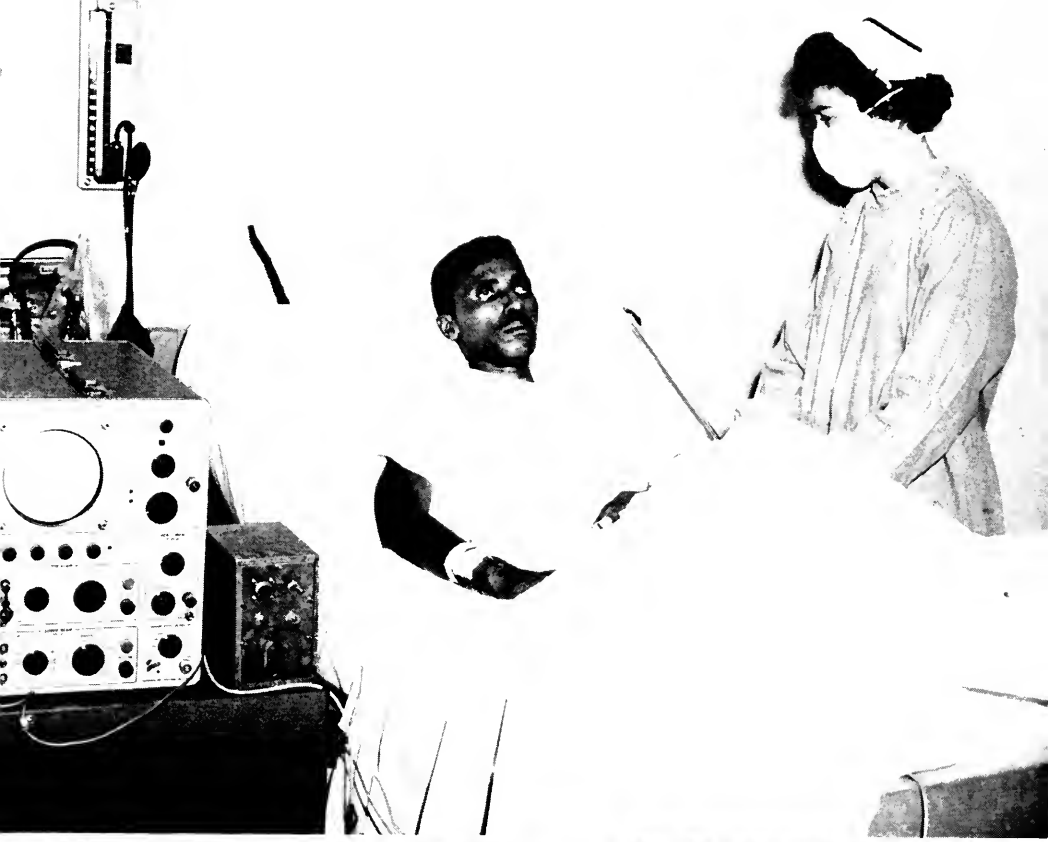
Many adjuncts to care as well as vital necessities are incorporated in monitoring devices, hypo-hyperthemia equipment, an electrocardiograph machine, a pacemaker-defibrillator, respirators and respiratory assistors available as standard equipment for the unit. These are only a few of the resources which enable the physician to institute immediate and detailed therapy when indicated.

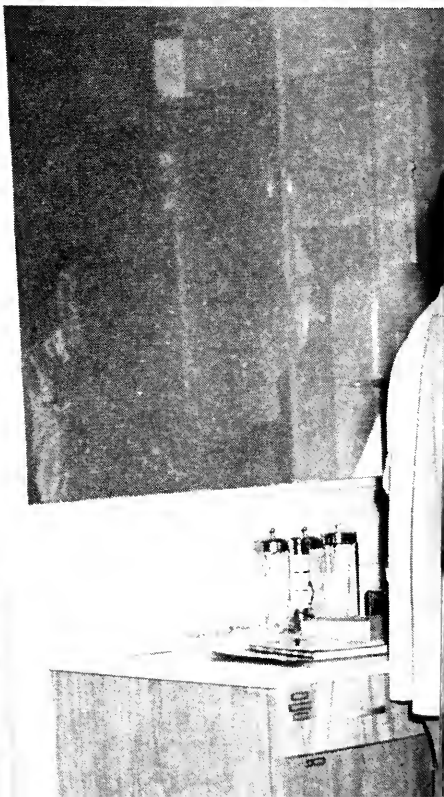
The complexity of care and the required closed observation of patients in this unit necessitate a proportionately higher ratio of nursing personnel than is the case in other units of the hospital. To date, personnel have been selected on the basis of expressed interest in this type of nursing care. Many have had experience in this area of nursing before; new nurses receive orientation to the hospital and to the unit. Every effort is made to assure the new nurse assistance and supervision until skill and experience are gained.

For all, this is an area in which the opportunities for new experiences and learning are constant; an area where the cooperative efforts of physician, nurse, and allied personnel are paramount in the provision of intensive care. Due credit must be given to all hospital departments and services who have contributed to the operation of this unit by willing and prompt extension of their services to this area.

Believing that no program can progress without periodic evaluation, an Intensive Care Committee representative of all clinical services, hospital administration, and nursing meets periodically to review progress and discuss and recommend improvements and procedures designed to maintain treatment and care on a level consistent with advances in medical practice.

See pictures pertaining to this article on the following two pages.






INTENSIVE CARE
UNIT
MADE POSSIBLE
THROUGH THE
GENEROUS
DONATIONS
OF THE
UNIVERSITY OF
NORTH CAROLINA
N. C. MEDICAL CARE
COMMISSION
WOMEN'S HOSPITAL AUXILIARY

WILLIAM W. MCLENDON, M.D., '56, a previous member of the Department of Pathology of the University of North Carolina, is currently a Captain in the Army Medical Corps.

Glimpses of Medical Europe

1961-1963

(Part I)

The title for this paper is borrowed from that of a book by another pathologist—Dr. Ralph L. Thompson, late Professor of Pathology at the St. Louis University School of Medicine—who wrote a book with the title *Glimpses of Medical Europe* in 1908 following a tour of medical centers in Europe.

My opportunity to have a series of glimpses of medical Europe was provided by the U. S. Army when I went on active duty in July of 1961 after having completed my residency training in pathology at Chapel Hill under the Army's Berry Plan (by which physicians with military obligation are deferred from active duty until they complete their residency). After a brief period of orientation to the Army Medical Service at Fort Sam Houston, San Antonio, Texas, I was sent to Germany in August 1961 to be stationed at the 2nd General Hospital.

My family arrived in September of 1961 and we are living in a comfortable German apartment in the town of Landstuhl within walking distance of the U. S. Army Hospital. Landstuhl is a small town in the *Land* (state) of the Rhineland-Pfalz and is located near the French border, about one hour west of Heidelberg (figure 1).

U. S. Army Medical Service in Europe

In peacetime the Army Medical Service in Europe comes under two general administrative channels, which would be consolidated in time of war. Most of the larger hospitals and some of the other medical facilities are under the control of the U. S. Army in Europe (USAREUR) with headquarters in Heidelberg, while the field hospitals and many of the troop dispensaries are directly under the 7th Army. In practice, the entire medical service works together to provide medical care for the troops and their dependents in Europe.

In order to better coordinate medical care in time of peace or war, the Army Medical Service in Germany and France has been organized into Hospital Centers for administrative purposes. Formerly there were two hospital centers in Europe with the 9th Hospital Center here in Landstuhl coordinating the medical activities for all of France and northern Germany. The 9th Hospital Center has recently moved to Heidelberg and now covers all of Germany while a new center is being activated in France for that area. Within the hospital centers there are medical service areas with coordinated groups of

Figure 1. Map of Europe with some of the principal medical centers.

Figure 2. Aerial view of Landstuhl Army Medical Center, Germany. The 2nd General Hospital is in the center and the town of Landstuhl is in the background.

dispensaries and small hospitals under a larger general hospital. This plan allows for better coordination of medical care in an area and promotes cooperation among the physicians at the various levels. The latter is a two-way affair with the specialists in the general hospital making periodical consultation visits to the smaller units and the dispensary physicians (when they can find the time) coming to the hospitals for conferences and rounds.

The 2nd General Hospital is located at the Landstuhl Army Medical Center (which is a geographic designation and is not to be confused with the hospital centers, which are purely administrative entities). This post is composed entirely of medical units, the largest being the hospital (figure 2). Other units stationed here include two 7th Army field hospital units; ambulance, ambulance train and helicopter units; a medical illustration unit; a nuclear medical research unit; and the USAREUR Medical Laboratory, which furnishes consultant services in tissue pathology and specialized laboratory facilities (such as toxicology and virology) for the entire European theater. My position is in the pathology service of the hospital, although we work closely with the pathol-

ogists in the USAREUR Medical Laboratory, which is located just across the street.

Physically, the 2nd General Hospital is like many other U. S. Army hospitals built in the early 1950's across Germany and France. Unlike many of the other hospitals, which are on a standby basis with none or only a few patients, the 2nd General Hospital has an average census of about 500 patients. The hospital can actually accomodate up to 1000 patients, but the remainder of the space is taken up by the many specialized clinics and facilities.

The 2nd General Hospital serves as the main referral center for the Army in Europe and has Board certified or qualified men in all of the major surgical and medical specialties. It also serves as a cardiovascular-renal center and has an artificial kidney and facilities for cardiac catheterization. Because of the fact that there is an intern and residency program for German physicians (the only one in an American hospital in Germany) there are numerous conferences, rounds and visiting consultants. Among the latter there have been visits by Dr. Zollinger of Ohio State in surgery and Dr. Edward Smith of Indiana University in pathology. Monthly meetings of the Western Germany Armed Forces Medical Society are also held in this area; these are attended by U. S. Army and Air Force physicians, RCAF physicians, and civilian German physicians from this area and the nearby medical school. The yearly Medical and Surgical Training Conference for the U. S. Army, Europe, is generally held in Garmisch, Germany, in May.

Germany

Germany has had a socialized system of medical care since the end of the last century and most of the workers are insured under the various *Krankenkassen* (health insurance plans). Those who can afford it also can go to the medical centers as private patients. Although it is difficult to make general statements regarding the relative quality of medical care, one does get the impression that on the local level many of the things which we now take for granted (such as intravenous fluids and blood transfusions) are seldom used and that the convalescence from even minor operative procedures is inordinately prolonged. On the other hand, the type of medical care given in the larger centers appears to be of high quality. The physical facilities of both the local hospitals and the medical schools in Germany are undergoing a period of great expansion. Although much progress has been made in this direction in recovering from the war damage and in modernization of the remaining facilities, the greater problem of replacing the medical men lost by war and forced emigration will take much longer to solve.

The Federal Republic of Western Germany now has 19 medical schools; 17 of these are schools associated with universities while the two medical academies at Dusseldorf and Giessen provide only the clinical part of the curriculum. The pre-medical education in Germany generally consists of four years of primary school (average age, 6 to 10 years) and nine years of secondary school (average age, 11 to 19 years). A certificate, based on oral and written examinations, attesting to the completion of a course of secondary education and some knowledge of Latin is generally all that is required for medical school admission. The academic year in the medical schools is divided into two semesters, the Winter Semester running from November to February, and the Spring Semester running from May to July. During the remaining five months of the year the student is expected to study for his examinations or to spend a period of clinical clerkship in a hospital. The medical curriculum

itself is divided into a pre-clinical period of two-and-a-half years (five semesters) followed by the pre-clinical examination known as the *Physikum*, and the clinical period of three years (six semesters), which is followed by the clinical or qualifying examinations. Most of the examinations are oral and practical in nature rather than written. Successful completion of the medical course gives the title of *Medizinalassistent* but does not lead to a university degree; the university degree of *Doctor medicinae* (Dr. Med.) may be subsequently obtained by submitting a thesis containing the results of original research or observation. Following the completion of the required two years of internship, the physician is issued a license to practice by the health department of the *Land* (state) in which the final qualifying examination in medicine was passed. This license entitles the holder to practice in any of the states of the Federal Republic.

The nearest medical school to Landstuhl is the Medical Faculty of the University of the Saar. The coal-rich Saar has been somewhat of an international football for years. In 1935 it returned to German rule, but following the war it was again under French rule. As a result of a plebiscite it reverted to Western Germany on 1 January 1957 and became one of the German *Lander*. Shortly after the Second World War the University of the Saar was founded by the French at Saarbrucken (the capital of the Saar) with the Medical Faculty at Homburg at the site of an old mental hospital (figure 3). Homburg (which should not be confused with Hamburg in northern Germany) is located in the Saar about 20 miles west of Landstuhl. Because of the proximity

Figure 3. Aerial view of the Medical School of the University of the Saar, Homburg, Germany.

to the Army hospital here there have been a number of close contacts between members of the various specialties at the American hospital here and their counterparts in the University. I have been fortunate to be able to visit the Pathology Institute there several times and to attend some of the weekly lectures given on Friday evenings for the entire Medical Faculty. I was particularly pleased to hear a lecture by the son of the famous German pathologist Karl Aschoff (1866-1942); the younger Aschoff is a physiologist working in Bavaria and gave an enthusiastic presentation of his researches on cyclic biological phenomenon.

The German university best known to Americans is the University of Heidelberg. The city itself is picturesquely located in a valley along the Neckar River and is dominated by the famous Heidelberg Castle which overlooks the old city. The Medical Faculty, like the other faculties, is located in the old city, in an area of several blocks overlooking the river. The University does have long-range plans to move many of its functions across the river to a large plot of previously undeveloped land. Several of the medical facilities have already moved to the new campus while others are to follow in the next few years. The present Pathology Institute is located in a spacious old building which contains among other things a well-equipped laboratory for electron microscopy. Plans for the new building for the Pathology Institute are being made and the building should be completed in a few years. The present chief of the Pathology Institute is Professor Lennert, who has just published a monumental work on diseases of lymph nodes in the new revision of the Henke-Lubarsch *Handbuch der speziellen pathologischen Anatomie und Histologie.*

During a recent trip to Nurnberg, I had the opportunity to stop briefly at the University of Wurzburg. It was here that Wilhelm Conrad Roentgen, then Professor of Physics at the University, discovered the X-ray in November 1895. As might be expected, one of the most impressive buildings at the University is the Roentgen Institute, which is located on one of the main streets known as *Roentgenring*. The Institute building, which is in the process of a further expansion at the moment, has a large plaque on the outer wall commemorating Roentgen's discovery. Inside the newer wing of the building is a display case containing many items relating to Roentgen's personal and scientific life. While at the University we stopped briefly at the Institute of Medical History which is located in a small two-story building behind the Roentgen Institute. The Professor of Medical History had recently left Wurzburg to accept the professorship of medical history at the University of Kiel (in northern Germany), which I am told has a large and active medical history institute with many resources in ancient and medieval medical history. His assistant, Dr. Kudlien, who will also go to Kiel in the next year, was present and gave us a brief tour of the Institute's library. Dr. Kudlien was delighted to learn that I had studied at Chapel Hill for he had recently met Professor MacKinney of the U.N.C. History Department and had corresponded with him. Because of limitation of time I did not have the chance to search out the Pathology Institute at Wurzburg, where Rudolf Virchow had been Professor of Pathology from 1849 until his return to Berlin in 1856.

In visiting and observing the medical schools in Germany, one is struck with several obvious differences between the German and American systems. From the physical standpoint, one of the first impressions one gains is the presence of the many separate institutes, as contrasted to our system of medical school departments located within a single building or several connecting buildings. Although the German system has the obvious advantage of having smaller, more compact units where there is less distraction, it would appear to foster a narrowness of viewpoint. From the standpoint of the students, the German system of medical education is much more flexible than the American system. For one thing, it is possible for the student to shift freely from one medical school to another. At least in the past this was used as a method of taking advantage of the best teachers and strongest departments in several medical schools. Also, unlike our rather rigid system of classes of students which proceed together through the curriculum in a lock step fashion. the German student can more or less set his own pace within the limits of the requirements for the examinations. This has obvious advantages for the good students, but on the other hand appears to result in much wasted effort and a large drop-out rate. The third major difference which I have noted is the apparent retention in many areas of the Prussian approach to education as characterized by the aloof and dogmatic professor whose word is never questioned. For one who attended a medical school such as that of Chapel Hill where there is a friendly student-faculty relationship and an emphasis on development of the student's intellectual inquisitiveness, the German attitude comes as somewhat of a shock. In fairness, it should be said that there is evidence of many changes for the good in the last few years, but it does appear that the Prussian approach is slow to die.

(Dr. McLendon will conclude this article in a future edition of *The Bulletin* with an account of his experiences in Austria, France, England and Scotland.)

Presenting the Alumni

DR. W. E. CORNATZER

Dr. W. E. Cornatzer, professor and head of the Department of Biochemistry and Director of the Ireland Research Laboratory at the University of North Dakota School of Medicine, is a native of Mocksville and a three-way alumnus of UNC.

He received his M.S. in Biological Chemistry here in 1941, his Ph.D., in that field in 1944 and attended the School of Medicine from 1944 to December 1945. From 1941 to 1945 he was a Fels Research Fellow at UNC.

Dr. Cornatzer received his M.D. from Bowman Gray in 1951. He served there as assistant professor of biochemistry from 1946-51, with a year off for work at the Oak Ridge Institute of Nuclear Studies in 1948. He assumed his present position at North Dakota in 1951.

Dr. Cornatzer has won the American Medical Association's Frank Billing Award for Original Investigation and a silver medal for an exhibition on "The Role of Lipotropic Agents in Liver Disease," 1951; a National Science Travel Award to the Second International Congress of Biochemistry, Paris, France, 1952; an American Association for Cancer Research Travel Award to the Seventh International Cancer Congress, London, 1958; and an International Union of Physiological Science Travel Award to the First International Pharmacological Meeting in Stockholm, 1961.

Currently a member of the Biochemistry Test Committee of the National Board of Medical Examiners and a consultant to the Medical Division of the Oak Ridge Nuclear Institute, Dr. Cornatzer is a widely-known medical scholar responsible for a sizable number of publications in various fields of medicine.

Presenting the Faculty

DR. MARGARET C. SWANTON

Dr. Swanton has been a member of the Pathology Staff since 1947, although she had worked as a research Assistant to Dr. Russell Holman in the Pathology Department during her years as a medical student at UNC. She received her medical degree from Johns Hopkins University in 1946, where she was a member of AOA, and served in a rotating internship at State University of Iowa Hospitals. She returned to Chapel Hill for a fellowship in Pathology as a background for the practice of internal medicine, but found the field of pathology more to her liking and entered the academic ranks as an Instructor in the department that then consisted of only Drs. Brinkhous and Graham. In 1949, "just in case this new exfoliative cytology might become important," she spent time receiving special training in cytology at McGill University and in Dr. Papanicolaou's Laboratory at Cornell. She now directs the Cytology Program in the department which serves NCMH and many physicians throughout the state. She also directs a cytology training program sponsored by a USPHS Cancer Control Grant. Dr. Swanton's other special interest is neuropathology, a field in which she received special training in the Neuropathology Laboratory at the College of Physicians and Surgeons in N. Y. In addition to a number of articles on neuropathologic subjects, she has published accounts of her rather extensive studies of hemophilic arthropathy.

DR. CHARLES ELLIOT MORRIS

Dr. Morris, a native of Denver, Colorado, joined the faculty as Assistant Professor of Neurology in 1961. As an undergraduate he attended Stanford University and subsequently received an M.A. in chemistry from the University of Denver. He attended the University of Colorado School of Medicine from 1951 to 1955, where he was president of the Alpha Omega Alpha Chapter and recipient of several awards for scholarship. After an internship at Los Angeles County General Hospital, Dr. Morris chose the field of clinical Neurology, left the West and came East to complete the training program at the Harvard Neurological Unit of Boston City Hospital. He was certified in Neurology in 1962.

While in the Navy, Dr. Morris was in charge of Neurology at the U.S.N. Hospital, Portsmouth, Virginia.

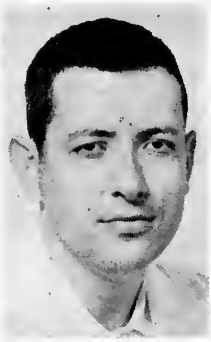
His research interests particularly concern autoimmune diseases of skeletal muscle and he has entered upon a course of investigation using the tool of tissue culture.

Dr. Morris' wife, Naomi, also a physician, is affiliated with the School of Public Health. They have two sons: Jonathan, 6, and David, 4.

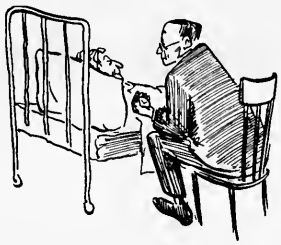
Presenting the House Staff

DR. HUGH M. SHINGLETON

Dr. Shingleton, a native of Wilson, North Carolina, is an American Cancer Society Fellow serving in the Department of Obstetrics and Gynecology. He received his baccalaureate in 1954 and the M.D. degree in 1957, both at Duke University. After a rotating internship served at Jefferson Medical College Hospital he went into the Medical Corp of the Air Force. At Webb Air Force Base in Texas he had duty as Chief, Aviation Medicine, and Chief of Professional Services. In July, 1961, he was appointed first year assistant resident in obstetrics and gynecology. He was an exchange resident at The Margaret Hague Maternity Hospital and has served six months in the Department of Pathology. At present he is resident in charge of the gynecology tumor clinic, coordinating the care of and organizing the data for such patients. In July, 1963 he will become Chief Resident and Instructor in the department.



He is married to the former Lucy Koesy, of Miami, Florida and they have one son.



ALUMNI NEWS ITEMS

CLASS OF 1945

DAVID G. BUNN, 107 N. Thompson St., Whiteville, N. C. Does general practice, solo. Postgraduate training was done at Medical College of Virginia. He and his wife, Mozelle, have two children: David, age 12, and Candace, age 6. A member of the Baptist Church, golf is his favorite recreational activity.

A. ROBERT CORDELL, Bowman Gray School of Medicine, Winston-Salem, N. C. Is Assistant Professor of Surgery at Bowman Gray. Postgraduate training was done at Johns Hopkins, Yale, and Bowman Gray Schools of Medicine. Among professional honors are: Participant, special project in Medical education, University of Buffalo, 1956-'57, (Commonwealth Fund), and visiting instructor in Surgery, University of Buffalo School of Medicine, 1956-'57. He married the former Dewitt Cromer and they have two sons: Alfred Robert, 5, and Franklin Cromer, 3. He holds membership in the Winston-Salem Chamber of Commerce, Twin City Kiwanis and City Clubs and Old Town Club and is a member of the official board of the Centenary Methodist Church. He plays tennis occasionally.

WELDON H. JORDAN, 114 Broadfoot Ave., Fayetteville, N. C. An internist, he did postgraduate work at G. F. Geisinger Memorial Hospital; Dept. of Pathology, U.N.C. School of Medicine; and Medical College of Virginia Hospital in Richmond. He married the former Mary Lynn Haigler and they have four sons: Weldon, Jr., 7; Dick, 6; Stuart, 4½; and Peter, 3½. He is a member of the Vestry of Holy Trinity Episcopal Church in Fayetteville.

CHARLES ROBERT THOMPSON, 112 N. Boundary St., Lenoir, N. C. Is half owner of Dula Hospital, Inc., Lenoir, N. C. (A 50-bed private general hospital). Does general practice. Postgraduate training was received at Watts Hospital, Durham, and Spartanburg General Hospital in Spartanburg, S. C. He married the former Elizabeth Dula and they have two children: Charles, Jr., 9, and Jennie, 7. A Presbyterian and a Mason, he is a past president of the Community Chest. Bowling and golf are his chief recreational activities. He spent two years abroad in Germany.

CLASS OF 1946

JULES AMER, 1575 Vine St., Denver 6, Colorado. Does pediatrics in association with two other pediatricians. A member of the American Association of Pediatrics, he had his postgraduate training at the University of Cincinnati, Queens General Hospital (N.Y.), U. S. Public Health Service and University of Colorado Medical School. He and his wife, Marilyn, have three children: Lyle, 9; Manette, 7; and Janette, 8 months. He advises that he plays handball and "lost a recent tournament!" He reports interesting trips abroad to Italy in 1960 and Mexico in 1962.

WALTER C. BARNES, JR., Southern Clinic, 401 E. Fifth Street, Texarkana, Ark-Texas. Does general surgery in a twelve man group of diversified specialists. Following internship at Watts Hospital, Durham, N. C., he did a residency in surgery at Baroness Erlanger in Chattanooga, Tenn., followed by a one year fellowship with Dr. Guy Horsley in Richmond, Virginia. Certified by the American Board of Surgery, he holds membership in numerous surgical and medical associations; is a former president of the Bowie County Medi-

cal Society; former chief of the Surgical Staff, St. Michael's Hospital, Texarkana, Ark. (1959); Chief of Staff, Wadley Hospital, Texarkana, Texas (1960); and Chairman of the Surgical Service at Wadley (1958). He and Pauline have two children: W. C., III (Tad), age 8 and Abbiegail Ruth (Abbie), age 6. He is a member of the Official Board, Methodist Church, Texarkana, Arkansas, where he teaches a Sunday School Class and he is a member of the Board of Directors of the Four States Freedom Foundation and a member of the Board of the American Cancer Society for the Four States Area. Hunting, some fishing, and bowling are his recreational interests and he has had an interesting trip to the South Pacific under Army Sponsorship.

EDGAR T. BEDDINGFIELD, JR., Stantonsburg, N. C. Does general practice in partnership with Jack W. Wilkerson, '51 and P. Milton Moore, Jr., '59. He received his M.D. CUM LAUDE from Harvard Medical School, followed by postgraduate training at Walter Reed Hospital, Washington, D. C. Married to the former Lorraine Moore on Aug. 22, 1947, he and Lorraine have three children: Ed III, 12; Alice, 11; and Gladys, 6. A member of AOA (Alpha of Massachusetts), Joseph Waron Lodge No. 92 AFOAM, Elks Club, he is a deacon in the Stantonsburg Baptist Church and a past president of the Kiwanis Club and of the Wilson County Hunt Association. A recipient of the NEWS AND OBSERVER'S "Tar Heel of the Week" award, he plays golf on Thursday afternoons. He hopes for interesting trips abroad, but reports that there is too little time or money and that there is too much to do in North Carolina.

GEORGE WILLIAM FARRIS, 412 Medical Arts Building, Chattanooga, Tenn. Does anesthesiology in partnership with eight physicians. After an internship at Jefferson-Hillman Hospital, his first year of residency was done at Baroness Erlanger Hospital, Chattanooga, and his second year at Duke University Hospital. He is a diplomate of the American Board of Anesthesiology and chief of the Department of Anesthesiology of Baroness Erlanger Hospital. He and his wife, Sue, have two children: William Charles, 2½, and James Lee, 1. A deacon and choir member (bass) in the Lutheran Church of the Ascension (Chattanooga), his recreational activities include sailing, swimming, and photography. He had an interesting trip to Nassau some 3½ years ago.

VIRGINIA SUHRIE RONK, 100 N. Wycome Ave., Lansdowne, Pa. Professional activities are listed as: Academic — Consultating — Research — Teaching at the Hospital of the University of Pennsylvania in Philadelphia where she had her postgraduate training. She married W. L. Ronk and they have one son, Neil, age 5.

PETER SOMERS SCOTT, Route 2, Burlington, N. C. Classifies himself as a Rural G.P. who does general practice at Union Ridge, N. C. in association with his father, S. Floyd Scott, '16, and Dr. C. C. Shoemaker. Did postgraduate training at Duval County Hospital, Jacksonville, Florida (1947-48) and at Watts Hospital, Durham, N. C. (1948-49). He married the former Pamela Thompson and they have five children: Susan, 14; Valerie, 13; Jonathan, 11; Cynthia, 10;

and Michael, 7. He designates himself as an inactive member of the Union Ridge Congregational Church. He lays claim to no professional or community awards and honors "except hard and steady work." Among "occasional" recreational activities, he lists: "Rockhound," collector of Indian Artefacts, sports car enthusiast, sports car race fan (spectator only), and he plays tennis regularly on his own lighted court at home at night.

CLASS OF 1947

EDWARD P. KINGSBURY, 704 Todd, Union City, Tenn. Does pediatrics (partnership) in Union City Clinic which also includes 2 surgeons, 2 OB-GYN, 1 G.P., 1 internist, and 1 EENT. Postgraduate training was done at Duke and Watts Hospitals, Durham, N. C. He and his wife, Mary, have one son, Warren Harris, age 8. A deacon in the First Christian Church and a member of the Chamber of Commerce and Union City Country Club, his principal recreational interests are hunting, fishing, and golf.

THOMAS R. NEWITT, 3003 Deluna Drive, Rolling Hills, California. Does Anesthesiology. A diplomate of the American Board of Anesthesiology, he had his postgraduate training at the V.A. Hospital, West Los Angeles, California. He and his wife, Nina, have two children: Chris, 4, and Lance, 2. A ham radio operator, he reports contacts with North Carolina when ionosphere permits.

J. LLOYD PATE, 208 Iona St., Fairmont, N. C. A general practitioner in partnership with Chas E. Inman, he did his postgraduate training at Roper Hospital, Charleston, S. C. He married the former Bernice Russ and they have one son, James Lloyd, Jr. (Jim), 8. A member of the First Baptist Church, he is President of the Fairmont Rotary Club.

ROBERT R. ROSEN, 260 95th Street, Miami Beach 54, Florida. Has general practice. Served internship at Michael Reese Hospital and residency at Mount Sinai, Cleveland. He and his wife, Beatrice, have one son, Seth David, age 4.

HARRY GORDON WALKER, 310 Davie Ave., Statesville, N. C. Does general practice in partnership with John T. Stegall, '42. Postgraduate training was done at U. S. P. H. S. Hospitals at New Orleans and Savannah. He and his wife, Peggy, have three children: Gilda Anne, 14; Cheryl Jean, 11; and Harry G., Jr. 9. A deacon in the Wake Forest Presbyterian Church, he enjoys golf, gardening, and hunting.

CLASS OF 1948

JAMES H. GALLOWAY, 223 Bryan Bldg., Raleigh, N. C. Does general practice. Had his internship and Pediatric residency (1 year) at Rex Hospital, Raleigh, N. C. He and his wife, Eleanor, have one son, James H., III, age 9. A member of the West Raleigh Rotary Club, he reports an interesting trip to Grand Bahama Island in June 1962 and suggests that it might be a good place for a meeting sometime.

HENRY JOSEPH LIVERMAN, Engelhard, N. C. Does general practice (solo). Had one year internship at U. S. Naval Hospital, Portsmouth, Va. He and his wife, Kathryn, have three children: H. J., Jr., 10; Kathy, 8; and Walter, 2½. He is a lay leader in the Episcopal Church. A flying physician, he is a member of the Experimental Aircraft Association. He serves two offices by airplane, one at Engelhard and one at Fairfield, N. C.; plans to open third office at Ocracoke in Spring, 1963, on completion of airstrip there. He practices at Fairfield two half days a week and will be at Ocracoke one day a week (Wednesday). System operating one year now and very successful.

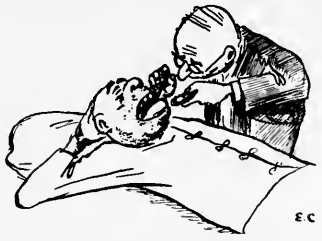
ANDREW A. MANNING, JR., 763 Plume Street, Spartanburg, S. C. Is not engaged in practice at present but hopes shortly to be doing general practice. Did postgraduate work at Charity, Grady, and Columbia Hospitals. A member of the Spartanburg Episcopal Church, his chief recreational activities are fishing and hunting.

EUGENE V. MAYNARD, Elm City, N. C. Does general practice in partnership with Dr. R. H. Putney, Jr. A member of A.M.A. and A.A.G.P., he reports that he did his postgraduate training "in the country with people." He and his wife, Eleanor, have two children: Katie, 10, and Jonathan, 8. A Baptist and member of the School Board, the practice of medicine apparently takes up any

time that might be used for recreational activities. Trips to Nash County and Wilson are reported as "interesting trips abroad."

EARLE SPAUGH, 126 Cottage Place, Charlotte, N. C. A pediatrician who had his postgraduate training at M.C.V. and U.N.C., he is a diplomate of the American Board of Pediatrics and has applied for membership in the American Academy of Pediatrics. He and Beckie have two children: Sue and Earle, Jr.

TOM A. VESTAL, 1958 member of the House Staff, recently announced the removal of his office from the Kinston Clinic to 1220 North Fant Street, Anderson, South Carolina. A diplomate in the American Boards of Obstetrics and Gynecology, he is in partnership with Dr. Rudolph H. Hand. He is married to the former Janis Ballentine and they have four daughters: Lyndon, 8; Collins, 6; Jan, 3; and Ansley, 1. Their home address is 2810 Echo Trail, Anderson, South Carolina. Both Tom and Janis are U.N.C. graduates, 1949 and 1951 respectively.



DEPARTMENTAL NEWS

BACTERIOLOGY

Dr. George Philip Manire, professor of bacteriology, will take a year's leave of absence from UNC to conduct research at the Institute for Virus Research of Kyoto University in Japan, beginning July 1. He has been awarded the Alan Gregg Travel Fellowship in Medical Education from the China Medical Board of New York for the year of study.

Dr. Manire's work will be in the Institute's Department of Biophysics with Dr. Noboru Higashi, a distinguished scientist whose work is in Dr. Manire's field of interest. Dr. Higashi has been especially recognized for his studies during the last few years on the utilization of new techniques in thin sectioning and electron microscopy to study the comparative structure and mode of reproduction of certain disease-causing viruses.

While in Kyoto, an old city near Tokyo, Dr. Manire plans to continue his own virus studies begun at UNC and to work for proficiency in the new techniques developed by Dr. Higashi and his associates.

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MEDICINE

Dr. William G. Wysor, assistant professor of medicine in the University of North Carolina School of Medicine, left Chapel Hill recently to begin a six-month teaching term at the Escola Paolista de Medicine in Sao Paulo, Brazil, under a program set up by the Rockefeller Foundation with the UNC Department of Medicine.

The program allows the Department of Medicine to extend its educational services through cooperation with foreign medical centers, particularly those of South American countries.

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PHYSIOLOGY

Dr. Panayotis G. Iatridis, is now associated with Dr. John H. Ferguson's Blood Coagulation Research Program as a Research Associate. Dr. Iatridis was assistant director of the Pathology Clinic at Greek Hospital, "Theochari Cozzica," Alexandria, Egypt prior to coming to Chapel Hill where he joined his brother, Dr. Sotirios G. Iatridis, who has been here several years in the capacity of Research Associate with Dr. Ferguson, Professor and Chairman of the Department. Dr. Iatridis received the M.D. degree in 1951 at the University of Athens and then specialized in internal medicine.

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PREVENTIVE MEDICINE

Dr. William L. Fleming, Chairman, Department of Preventive Medicine and Assistant Dean, resumed his duties, January 1, 1963 after a six months' leave of absence. Dr. Fleming served during this period as Consultant and Visiting Professor of Preventive Medicine in the Escola Paulista de Medicina, Sao Paulo, Brazil. This was arranged through a Rockefeller Foundation

grant to the Department of Medicine calling for staff assistance to the Escola Paulista de Medicina. Dr. James Woods served this institution as Visiting Professor during the last six months of 1961 and Dr. W. G. Wysor will serve in the same capacity during the first six months of 1963.

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PSYCHIATRY

Dr. Harvey L. Smith, director of the Social Research Section of the University of North Carolina Division of Health Affairs, was recently appointed Chairman of the newly constituted subcommittee on Pilot and Special Projects and Public Health of the National Institute of Mental Health's Training Branch.

Dr. Smith, who joined the UNC faculty in 1957, is professor of sociology in the Departments of Psychiatry and Sociology and Anthropology and a research professor in the Institute for Research in Social Science.

OBSTETRICS AND GYNECOLOGY

Dr. Charles E. Flowers, Jr., professor of Obstetrics and Gynecology was one of the three guest faculty at a postgraduate course in Obstetrics and Gynecology at the University of Nebraska College of Medicine, January 17 and 18.

Under the topic of "Complications of Late Pregnancy," Dr. Flowers presented a talk on the treatment of toxemia and participated in a panel on problem cases. He also spoke on "Dilatation and Curettage," "Premature Rupture of the Membranes" and "How We Suppress Lactation." The two-day meeting was held with the co-sponsorship of the Division of Maternal and Child Health, Nebraska State Health Department.

CLASS NOTES

Class of 1963

As one of the more optimistic members of our class said to me today, "Only 141 more days," meaning, I believe, that the closer we come to graduation, the closer we come to the partial fulfillment of something we all set out to accomplish at least eight or more years ago. There still is much to be done: senior papers to be written, national board exams to be endured, and student-faculty day to be plotted. But, even here in the gloom of January, the prospects look cheerful.

A good representation from our class was able to take advantage of the Christmas trip to New York City, co-sponsored by the Lederle and Squibb drug companies. In spite of the severe cold, everyone had the opportunity to see a few Broadway shows of his choice, as well as to participate in the planned activities, bacchanalian and otherwise. Following the narrow escape of one of our members whom we nearly lost over the balcony rail at Radio City Music Hall, we returned to celebrate the advent of the New Year in North Carolina.

On the nativity scene, Richard and Patsy Pressley are the proud parents of a new son. Also, Everette and Jeanette James are the parents of a new daughter, whom we acknowledge, even though her father will graduate this year from a neighboring institution in Durham, N. C. Rumor also has it that one of the last of the bachelors in our midst, Larry Taylor, will soon join the ranks of the connubial confirmants.

Quincy Ayscue, 1963???

Class of 1966

The officers of the class of 1966 are: Bob Bilbro, President; Jake Lohr, Vice-president; Beth Spivey, Secretary; Bev Tucker, Treasurer; Bob Sevier, Whitehead representative; Bill Rawls and Bill Riley, Honor Council representatives; and Bill Hubbard, intramural manager.

In order to ease the pain of resuming classes after Christmas vacation, the class took time out January 12 for a therapeutic evening together. The party, held at the American Legion Annex, was enjoyed by all. It helped some members of the class to gain an appreciation for the "Carolina way of life."

Some members of the class are initiating a series of evening discussions with faculty and staff personnel. The hope is that these meetings will prove to be valuable in acquainting us better with our faculty and with some important extracurricular aspects of medical practice.

The class has had good participation in intramural sports. The football team finished the season as runners-up in the graduate division play-off against the lawyers. Two basketball teams are putting their free afternoons to good use this quarter. They are acquiring invaluable experience in the treatment of blisters.

Elliott Walker Stevens, Jr., son of Mr. and Mrs. E. Walker Stevens of Warsaw, has been named as the first recipient of the recently established Pfizer Laboratories Scholarship at the University of North Carolina School of Medicine.

This is the first time that UNC has participated in the Pfizer Scholarship program. The Pfizer Laboratories Division of Charles Pfizer & Co., Inc., awarded UNC one thousand dollars for the initial scholarship, to be given in the interest of furthering medical education through financial assistance to a particularly deserving student. The Scholarship is to apply toward the academic . . . .

Remember . . .

Medical Alumni Day—March 22

Medical Parents Day—April 6

—Plan Now To Attend—

HO HUM

another year has gone by. For Hospital SAVING Association of Chapel Hill, it was a record-breaker. Enrollment is at an all-time high. So are Blue Cross and Blue Shield payments to doctors and hospitals!

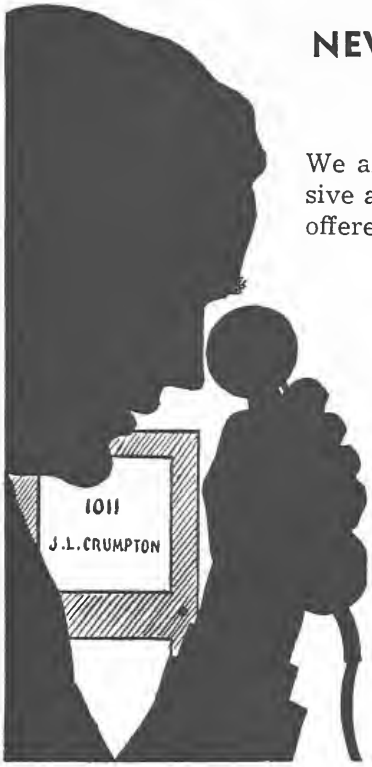
Thank YOU for helping to make it all possible!

Vol. X APRIL, 1963 No. 4

THE BULLETIN

School of Medicine
University of North Carolina

THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA ESTABLISHED THIS PLAN OF GROUP ACCIDENT AND HEALTH PROTECTION FOR ITS MEMBERS IN 1940



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5,000	5,000 to 10,000	50.00 Weekly	$ 78.00	$ 39.50	$104.00	$ 52.50
5,000	7,500 to 15,000	75.00 Weekly	114.00	57.50	152.00	76.50
5,000	10,000 to 20,000	100.00 Weekly	150.00	75.50	200.00	100.50
5,000	12,500 to 25,000	125.00 Weekly	186.00	93.50	248.00	124.50
5,000	15,000 to 30,000	150.00 Weekly	222.00	111.50	296.00	148.50

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Owned and Operated by the University of North Carolina

We at Thalhimers Ellis Stone extend a sincere welcome to you and hope to be of service during your visits with us.

By way of introduction, may we conduct a thumbnail tour of our down-town Durham store, located on the corner of Main and Corcoran Streets?

The Parking Level . . . facing on Durham's spacious parking lot . . . offers gifts for the home, an excellent Linen department, home furnishings and decorating needs, and our own decorating services.

Our Main Floor . . . here is our Shoe Salon, specializing in duty shoes and shoes for casual or fashion wear . . . complete accessory lines for fashion or casual wear, a Men's Furnishings department, and a Stationery department that covers every need from impressive pens to fine personalized stationery.

Fashion Floor, Second, a grand array of better sportswear, suits, coats, dresses and millinery . . . and in particular the Bridal Salon and the After Five Salon . . . here also on this floor is our Sewing Center Annex carrying a full line of home sewing needs and notions.

A Young World, our Third Floor, covering the necessities of the Young from infancy to teenage . . . of note on the Third Floor is our Beauty Salon, staffed by excellent and up-to-date Stylists.

The Colony Shops comprise our Fourth Floor . . . popularly priced sportswear, shoes, and featuring Nurses' Uniforms . . . not to be forgotten is the complete selection of luggage, everything from attaché cases to carry-alls. The Fourth Floor also contains our executive, cashier's, credit and service offices.

THE BULLETIN

of the School of Medicine
of the University of North Carolina

Published in cooperation with the Whitehead Medical Society
and the Medical Foundation of North Carolina, Inc.

Vol. X April, 1963 No. 4

IN THIS ISSUE

Editorial Committee

Address all inquiries and communications to Emory S. Hunt, 117 Medical Science Building—or Box 957, Chapel Hill, N. C.

Published four times a year — October, December, February and April — Entered as third-class matter at the Post Office at Chapel Hill, N. C.

Charles C. Dudley of Huntersville, left, is the new president of the Medical Parents' Club. Here he talks with Dean Berryhill and three of the Club's other new officers: J. C. Cowan of Greensboro, first vice-president; Carl G. Pickard of Asheville, secretary; and Howard Holderness of Greensboro, second vice-president.

Medical Parents Meet

The Medical Parents' Club, in their seventh annual meeting here at the Medical School on April 6, had a fine day despite the rain. Three different special tours gave all the parents—new and old to the School—a chance to see facilities, and the barbecue lunch made just as good a picnic indoors as out.

Elected to guide the club through the coming year were Charles C. Dudley of Huntersville, president; J. C. Cowan of Greensboro, first vice-president; Howard Holderness of Greensboro, second vice-president; and Carl G. Pickard of Asheville, secretary.

Regional officers were elected as follows:

Region I: Chairman, J. L. Phillips of Kinston; Vice-chairman, W. S. Bost of Greenville.

Region II: Chairman, Frank Cella of Raleigh; Vice-chairman, Dr. Robert D. Croom of Maxton.

Region III: Chairman, H. H. Aderhold of Greensboro; Vice-chairman, L. O. Branch of Durham.

Region IV: Chairman, W. T. Harris of Charlotte; Vice-chairman, Dr. K. L. Cloninger of Newton.

Region V: Chairman, William F. Algary of Asheville; Vice-chairman, Dr. Donald R. Printz of Asheville.

New Fund Trustee is Donald S. Menzies, Sr., of Hickory.

A report on the Parents' Club Student Loan Fund was given by Mrs. Carl Pickard of Asheville, in the absence of Fund Trustee, Mrs. Zebulon Weaver.

Mrs. Pickard reported that the Fund had received from parents and friends a total of $7,671 as of March 31. The Fund has loaned out almost $15.000 since its founding, she said. Mrs. Pickard urged the parents' support in building the fund total to $10,000 as soon as possible.

THE CLASS OF 1963

WILLIAM PAGE ALGARY: Bill is 25 and from Asheville, N. C. He was graduated from Duke in 1959 with an A.B. degree in Chemistry. He and his wife, Ruth, along with their daughter, Kitty, will remain in Chapel Hill where Bill will do a straight medicine internship at N. C. Memorial Hospital. His future plans include more training ing in internal medicine. Phi Chi. Senior Class Secretary.

QUINCY ADAMS AYSCUE: Qunicy is 28 and from Monroe, N. C. He received his A.B. degree in history from U.N.C. in 1957. He and his wife, Margaret, will be moving to Danville, Pennsylvania, where Quincy will do a rotating internship at the George F. Geisinger Medical Center. He plans a residency in Anesthesiology. Phi Chi.

HARRIS HARTWELL BASS: "Bunky" is 25 and from Henderson, N. C. He was graduated from U.N.C. with an A.B. in English. Bunky and his wife, Rae, will move to Seattle, Washington, where he will do a rotating internship at the Virginia Mason Hospital. Phi Chi. He plans for the future a family practice.

NEIL CARMICHAEL BENDER: Neil is from Pollocksville, N. C. and is 25. He is a graduate of U.N.C. with an A.B. degree in History. His wife is Mary Dale. They will move to Seattle where he will do a straight medicine internship at the University of Washington. Plans a residency in internal medicine. Student body president.

WILLIAM PAUL BIGGERS: Paul is 25 and from Charlotte, N. C. He received his B.S. degree in Chemistry - Biology in 1959 from Davidson. His wife is Joyce. They have a daughter, Sarah Machelle. They will remain in Chapel Hill where Paul will do a straight surgery internship at N. C. Memorial Hospital. He plans more training in surgery. Will possibly remain in academic medicine. Phi Chi.

KARL F. BITTER: Karl is 27 and from Asheville, N. C. He was graduated from Davidson with a B.S. degree in Biology and Chemistry. His wife is Mary Gladys and they have two daughters, Diana and Allison. Karl will stay at N. C. Memorial Hospital and do an internship in straight Pathology. He plans to do a surgical residency. Phi Chi.

WILLIAM RICHARD BURKE, JR. Bill is 26 and from Wilson, N. C. He received his B.S. degree from U.N.C. Single. He will have a rotating internsh p at St. Mary's Hospital in West Palm Beach, Florida. He plans a residency in Psychiatry and a private practice in the South. Phi Chi.

JESSE ANDREW BURNAM: Andy is 26 and from Cordele, Georgia. He was graduated in 1958 from U.N.C. with an A.B. in Chemistry. He and his wife, Gloria, will remain in this area while Andy does a surgery internship at Duke Hospital in Durham. He plans a surgical practice. Phi Chi.

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* Edited by Mrs. Robert J. Cowan.

FRANKLIN DANFORD BURROUGHS:

Dan is 29 and from Charlotte, N. C. He was graduated in 1956 from Georgia Tech. with a B.S. in Chemistry. His wife is Melissa. They have a daughter, Shannon. Dan will do a rotating internship at Norfolk General Hospital, Norfolk, Virginia. He plans a General Practice residency.

BRUCE FRANCIS CALDWELL: Bruce is 29 and from Clyde, N. C. He received his B.S. degree from U.N.C. His wife is Janice and they have two boys, Brian and Jeff. Bruce will do a mixed Surgery internship at the Eugene Talmadge Memorial Hospital, Augusta, Georgia. He plans a surgical residency and practice in Western N. C. Bruce is president of the Senior Class.

IRWIN KELMAN COHEN: Kel is 28 and from Charlotte, N. C. He is a graduate of Columbia University, receiving his degree in English in 1959. He and his wife, Judie, have two children, David and Nancy Beth. They will move to Hanover, New Hampshire, where Kel will do a rotating internship at the Mary Hitchcock Clinic.

CHARLES LEE COOKE: Charley is 25 and from Davidson, N. C. He graduated from Davidson with a B.S. degree in 1959. His wife is Jane. They will move to Richmond where Charley will do a rotating internship at the Medical College of Virginia.

DONALD L. COPELAND: Don is 29 and from Davidson, N. C. He received his B.S. degree in Biology-Chemistry from Davidson in 1958. Carolyn, his wife, and their two daughters, Ann and Jan, will be in Augusta, Georgia, where Don will do a straight pediatric internship at the Eugene Talmadge Memorial Hospital. Plans family practice residency program.

ROBERT JENKINS COWAN: Bob is 26 and from Greensboro, N. C. He received his A.B. degree in chemistry from U.N.C. in 1959. Phi Chi. President of AOA. His wife is Caroline. They will move to New York City where Bob will do a straight medicine internship at Presbyterian Hospital. He plans a residency in internal medicine and will probably practice in N. C. Recipient of the William deB. MacNider Award.

JOHN W. DALTON, JR.: John is 25 and from Forest City, N. C. He is a graduate of U.N.C. where he received an A.B. degree in Chemistry in 1959. Single. He will intern at the Cleveland Metropolitan General Hospital in straight medicine. He plans a residency in internal medicine.

DAVE McALISTER DAVIS: Dave is 26 and from Roanoke, Virginia. He did his undergraduate work at Goettingen University, Germany, and at U. N. C. He has an A.B. degree in German. His wife is Joan. He will do a straight medicine internship at the University of Florida Teaching Hospital and Clinics in Gainesville, Fla. Phi Chi.

WILLIAM BROWN DEAL: "Willie" is a native of Forest City, N. C. and is 26. He received his A.B. degree in Chemistry at U.N.C. in 1958. His wife is Bibby. They will be in Florida at the University of Florida Teaching Hospital and Clinics in Gainesville. He has a straight medicine internship and plans to practice internal medicine in N. C. Phi Chi.

BENJAMIN EMERSON DUNLAP: Ben is 26 and from Wagram, N. C. He graduated from U.N.C. in 1959 with a B.S. degree. His wife is Suzanne. They have a son Benjie. He will do a rotating internship at the George F. Geisinger Hospital in Danville, Penn. He plans one year of general practice residency.

CLARENCE A. DUNN, JR.: Clarence is 30 and from New York City. He is a graduate of Hamilton College with an A.B. degree in Biology. Single. Phi Chi. He will do a mixed Medicine - Surgery internship at Roosevelt Hospital in New York City. Clarence plans a surgery residency and a practice in the southwest.

JOHN MICHAEL GALLAGHER: Mike is 27 and a native of Chapel Hill. His A.B. degree in philosophy is from U.N.C. His wife is Ann and they have a son, Walter. They will move to Madison, Wisconsin, where he has a mixed internship at the University of Wisconsin. Mike plans a residency in internal medicine. Phi Chi.

HENRY WALTER GEROCK, JR.: Henry is from Maysville, N. C. and is 28. He is a graduate of Duke with a B.S. degree in Zoology. Single. He will intern in straight medicine at the Eugene Talmadge Memorial Hospital, Augusta, Georgia. He plans a residency in medicine.

ROWLAND DALEY GOFF, JR.: Daley is 27 and from Dunn, N. C. He graduated from U.N.C. with an A.B. degree in History. Daley and his wife, Mott, together with their son, Chris, will be in Gainesville where Daley will do a straight surgery internship at the University of Florida Teaching Hospital and Clinics. He plans to complete boards in surgery. Phi Chi. Chairman Honor Council.

BENJAMIN MITCHELL GOODMAN, JR.: Ben is from Gates, N. C. and is 25. He received his B.S. degree from U.N.C. in 1960. Single. He will do a rotating internship at Norfolk General Hospital, Norfolk, Virginia. He plans a general practice residency.

JOHN PHILLIP GOODSON: Phil is from Mt. Olive, N. C. and is 25. He is a U.N.C. graduate with a B.S. degree in Medicine. His wife is Barbara and they have a son, John Phillip, Jr. They will stay in Chapel Hill while Phil does a straight surgery internship at N. C. Memorial Hospital. He plans to specialize in surgery.

IRA M. HARDY: Ira is 28 and from Raleigh, N. C. He received his A.B. degree in English from U.N.C. in 1959. His wife is Mary Ruth. Their children are: Skipper: Sandy, and Ann Robbins. Ira will stay in Chapel Hill at N. C. Memorial Hospital doing a straight surgery internship. He plans a surgery practice. Phi Chi.

GEORGE CAPERS HEMINGWAY, JR.: George is a native of Winston-Salem and is 27. He received his A.B. degree in Biology - Chemistry from Davidson. His wife is Lynn and they have a daughter, Susan. George will do a mixed medicine-pediatrics internship at N. C. Memorial Hospital. He plans a Medicine and Pediatrics residency. Phi Chi.

LARRY KENT JACKSON: Larry is from Durham, N. C. and is 25. He received his B.S. degree from U.N.C. His wife is Sandra and their children are Gregory Kent and Lori Ann. He will do a mixed Pathology-Medicine internship at the Medical College of South Carolina in Charleston. He will specialize in internal medicine.

WILLIAM OSCAR JOLLY III: Bill comes from Ayden, N. C. and is 26. His A.B. degree in History is from U.N.C. Nancy is his wife and their son is Will. Bill will do a rotating internship at Norfolk General Hospital, Norfolk, Virginia. After his residency he plans a general practice. Phi Chi.

WALTER BRYAN LATHAM: Bryan is 24 and comes from Bethel, N. C. He received his B.S. degree from U.N.C. in 1960. Single. Phi Chi. Bryan will do a mixed surgery internship at the Medical College of Virginia. He plans a practice in General Surgery.

RAYMOND HAROLD LEWIS: Raymond comes from Winston-Salem and is 26. He graduated from Furman in 1959 with a B.S. degree in zoology. Single. Phi Chi. He will do a straight medical internship at Duval Medical Center, Jacksonville, Florida.

CHARLES IVEY LOFTIN III: Charles is 25 and from Gastonia, N. C. He received his B.S. degree in Chemistry - Biology from Davidson in 1959. He and his wife, Alice, will move to Augusta, Ga. where Charles will do a straight medicine internship at the Eugene Talmadge Memorial Hospital. He plans more training in Medicine. Phi Chi.

JOHN MARSHALL McLEAN: "Mac" is from Ayer, Mass. He received his A.B. degree in Biology from Amherst. His wife is Cindy. They will move to Chicago, Illinois where he will do a straight medicine internship at Presbyterian-St. Luke's Hospital. Alpha Kappa Kappa.

CARROLL L. MANN III: Carroll is 29 and from Raleigh, N. C. He is a graduate of N. C. State College with a B.S. degree in Zoology. He and his wife, Marion, will remain in Chapel Hill while Carroll does a surgery internship at N. C. Memorial Hospital. His future interests are in Neurological Surgery.

WALTER FORD MAUNEY: Walt is 24 and comes from Murphy, N. C. He received his B.S. degree in Medicine from U.N.C. in 1960. Single. He will do his rotating internship at the University Hospital and Hillman Clinic in Birmingham, Alabama. His plans for the future may include general practice after residency or a residency in Ob-Gyn.

JAMES LEE PARKER: Jim is 24 and comes from Enfield, N. C. He received his B.S. degree in Medicine from U.N.C. in 1960. A.O.A. He will take a straight pathology internship at the Eugene Talmadge Memorial Hospital. He plans a pathology residence and a practice in eastern N. C. He will marry Miss Martha Bowman of Hickory in June.

EUGENE W. PATE, JR.: Gene is from Kinston and is 27. He received a B.S. degree from The Citadel in 1958. Single. He will intern at the University Hospital, Birmingham, Alabama. Phi Chi.

RICHARD LaMARR PRESSLEY: Dick is 25 and from Gastonia, N. C. He is a graduate of U.N.C. with a B.S. degree in Medicine. His wife is Patricia and their son is Richard, Jr. He will do a straight surgery internship at N. C. Memorial Hospital. He plans a residency in Neurosurgery.

TOM SLADE RAND: Tom is 26 and comes from Fremont, N. C. He received his A.B. degree in English from U.N.C. His wife is Mary Margaret. They have two sons, Slade and Walter. They will stay in Chapel Hill where Tom will do a straight surgery internship at N. C. Memorial Hospital. He plans a Surgical Residency.

DOUGLAS LAMAR RITCH: Doug is 30 and from Belmont, N. C. He received his B.S. degree in medicine from U. N. C. in 1960. His wife is Helen. They will move to Norfolk, Virginia, where Doug will do a rotating internship at Norfolk General Hospital. He plans a family practice resi ency and practice in piedmont North Carolina.

CHARLES JUDSON SAWYER III: Charlie is 30 and a native of Windsor, N. C He holds an A.B. degree in Chemistry from U.N.C. His wife is Lois and they have a daughter, Kathy. They will be in Charleston where Charlie will do a rotating internship at the Medical College of South Carolina. He plans a general practice residency. Phi Chi.

HORACE KIMBRELL SAWYER, JR.: "Buzz" is 32 and is from Atlanta, Georgia. He received a B.S. degree in Chemistry in 1954 at the University of Miami in Florida and a M.S. degree in Physiology in 1959 at Florida State University. His wife is Mary Frances and their son is "Kim." He will do a rotating internship at the Georgia Baptist Hospital in Atlanta. He plans future training and practice in Ob-Gyn in Georgia.

SAMUEL E. SCOTT: Sam is 25 and from Burlington, N. C. He received his A.B. degree in History from U.N.C. in 1959. His wife is Connie and they will move to Little Rock, Arkansas, where he will do a mixed internship at the University Hospital. He plans a general practice residency. Phi Chi.

STEPHEN ROGER SHAFFER: "Step" is 25 and a native of Tryon, N. C. His undergraduate work was done at Duke University. His fiancee is Margaret Calhoun from Tryon. He will do a rotating internship at St. Luke's Hospital in Cleveland, Ohio. In the future he plans general and orthopedic surgical residencies. Phi Chi.

RICHARD W. SHERMER: Dick is 27 and is from Winston-Salem, N. C. He received an A.B. degree in Chemistry from U.N.C. in 1957. Single. He will do a straight pathology internship at N. C. Memorial Hospital. He plans to continue in straight Pathology. Phi Chi.

DAVID WILDE SILLMON: Dave is from Greensboro, N. C. and is 26. He did his undergraduate work at High Point College and U.N.C. in Chemistry. His wife is Gertrude. They will move to Harrisburg, Pennsylvania, where Dave will do a rotating internship at Harrisburg Hospital. He plans a general practice.

JERRY ALLEN SMITH: Jerry is 27 and from Salisbury, N. C. He is a graduate of U.N.C. where he received his B.S. degree in Medicine. Single. A.O.A. He will do a straight Pediatrics internship at the University Hospital, Western Reserve, Cleveland, Ohio. He plans a residency in pediatrics.

EDDIE PHILLIPS STILES: Eddie is 32 and from Newton, N. C. He is a 1957 graduate of Lenoir-Rhyne with a B.S. degree, and a M.S. degree in Biochemistry from U.N.C. His wife is Loretta and their son is Phillip. He will do a rotating internship at Roanoke Memorial Hospital, Roanoke, Virginia. He plans additional training for family practice.

FRED DAVIDSON SUMMERS, JR.: Fred is from Statesville, N. C. and is 30. He received his A.B. degree in English from Davidson. Marie is his wife and their two daughters are Anita and Adele. They will be in Danville, Pa., where Fred will do a rotating internship at the George F. Geisinger Hospital. He is interested in a general practice.

CHESTER WINFIELD TAYLOR, JR.: "Chet" is 25 and a native of Castle Hayne, N. C. His B.S. degree in Medicine is from U.N.C. Single. Phi Chi. He will do a rotating internship at St. Mary's Hospital in West Palm Beach, Florida.

LAWRENCE ARTHUR TAYLOR: Larry is from Reidsville, N. C. and is 26. He received his A.B. degree in History from U.N.C. in 1959. He will do a pathology internship at Duke Hospital in Durham. He is interested in a career in academic medicine. He plans to be married in June.

WILLIAM HOWARD TAYLOR: Bill is 25 and from Aberdeen, N. C. He received his A.B. degree from U.N.C. in 1959. His wife is Anita and their daughter is Kathryn. They will go to Gainesville where Bill will do a straight medicine internship at the University of Florida Teaching Hospital and Clinics. He plans an internal medicine residency.

WILLIAM E. THORNTON: Bill is 33 and from Faison, N. C. He received a B.S. degree in Physics from U.N.C. in 1952. His wife is Jennifer and their two sons are Simon and James. Bill will have a fellowship in Anesthesiology at N. C. Memorial Hospital next year.

WARD LANDIS VOIGT: Lanny is from Greensboro, N. C. and is 26. He is a 1959 graduate of Davidson with a B.S. degree. His wife is Peggy and they have a son, Jim. Lanny will do a straight surgery internship at the University of Florida Teaching Hospital and Clinics in Gainesville. He plans a surgical residency. Phi Chi.

KELLEY WALLACE, JR.: Kelley is 27 and from Chicod, N. C. He received his A.B. degree in Zoology from U.N.C. His wife is Calla Ann. They will move to Syracuse, N. Y., where Kelley will do a straight surgery internship at the Syracuse Medical Center. He plans a general surgery residency and a practice in N. C. Phi Chi.

ROY ALBERT WEAVER: Roy is a native of Newton Grove, N. C. and is 25. He received his B.S. degree in Medicine from U.N.C. His wife is Anita and their daughter is Gail Veronica. Roy will do a straight pathology internship at N. C. Memorial Hospital. He plans a residency in pathology. Phi Chi.

JACK H. WELCH: Jack is from Williamston, N. C., and is 31. He is a graduate of U.N.C. with a B.S. degree in Business Administration. His wife is Jean and they have three children: Jacqueline, Kathryn, and Robert. Phi Chi. Jack will do a mixed internship at the University of Kentucky Medical Center in Lexington. His future interests are in anesthesiology.

JAMES GRADY WHITE: Jim is from Charlotte and is 29. He received his A.B. degree in chemistry from U.N.C. Phi Chi. His wife is Wes and their son is Jamie. Jim will do a straight pediatrics internship at the University of Florida teaching Hospital and Clinics in Gainesville. He plans a pediatric residency and a private practice in Charlotte.

THEODORE CLARK WHITSON: Ted is 25 and is from Relief, N. C. He is a graduate of Berea College in Kentucky with a B.S. degree in Chemistry. His wife is Shelby. They will stay in Chapel Hill where Ted will do a straight surgery internship at N. C. Memorial Hospital. He plans a residency in general surgery and a surgery practice in Western N. C. Phi Chi.

DAVID ROBERT WILLIAMS: David is 25 and from Biscoe, N. C. He has an A.B. degree in History from U.N.C. His wife is Jane and they will remain in Chapel Hill while David does a straight pediatric internship at N. C. Memorial Hospital. He plans a pediatric practice in North Carolina. Phi Chi.

Glimpses of Medical Europe 1961-1963

(Part II)

by William W. McLendon, M.D., '56

Berlin

Berlin, the former capital of Germany, is now the one remaining occupation zone in Europe. Although surrounded by Russian-occupied territory since World War II and divided into four occupation sectors, it was not until after 13 August 1961 when the infamous Wall was begun by the Communist regime that Berlin became the divided city it is today. There are now about 2,200,000 persons in the Western Zone of the City and 1,100,000 persons in the Eastern Zone.

By supplying inexpensive transportation and lodgings, the Army indirectly encourages visits to Berlin by servicemen in order for as many as possible to see first hand the nature of the Communist threat. In addition to those who go on their own, the Army regularly takes groups of enlisted men and noncommissioned officers to Berlin as part of "Operation Look-See" for the same reasons. The overnight ride from Frankfurt to Berlin on the duty train is rather exciting in its implications but went without incident for us. The cars for the train are supplied by the U. S. Army but the engine for the portion of

The Bulletin presents herewith the second and final installment of Dr. McLendon's paper entitled "Medical Glimpses of Europe."

Though somewhat longer than our usual article, it is presented in but slightly abridged form because we consider it to be an excellent personal view of many aspects of contemporary European life in general and medicine in particular. That it is also a "refresher course" in medical history is attributable to the author's zeal for his avocation.

the trip through the Communist-held territory is furnished by the East Germans. When the train stops in Marienborn and Potsdam for the engine changes, it is on an enclosed track and is closely guarded by Russian guards to assure that no one gets on it. The train itself is guarded only by the U. S. Military Police and no Communist guards are allowed aboard. In order to go on the train, one must have his passport or Army ID card as well as travel orders with Russian translations. These are processed by the train commander, who then shows them to the Russian officer at the checkpoint at Marienborn, so that the passengers actually have no contact with the Russians or East Germans.

Our first effort after arriving in Berlin in the early morning and checking into the Army hotel was to take a bus tour of the city. Since my wife was ineligible to take the Army tour we chose to go together on the commercial tour. The East Zone still allows some tours through East Berlin, but these are limited in number and a Communist guide is furnished for the East Berlin portion of the trip. As members of the occupation forces, American servicemen in uniform can freely pass over the border into East Berlin and are under

Figure 4. Map of Europe with some of the principal medical centers.

orders not to show identification papers to the East Germans. Since most of those on our tour bus were civilians, however, the bus was delayed some 30 minutes as we entered and left East Berlin at Checkpoint Charlie while the East German border guards carefully checked each of their passports. While this was being done other guards scrutinized the exterior of the bus to assure that no one or nothing was being brought into or out of East Berlin. Because of the presence of the East Berlin guide the tour in East Berlin stressed the reconstructed buildings, the new apartment buildings and the large Russian War Memorial Park. Upon returning to West Berlin and again getting our West Berlin guide, we obtained a more realistic impression of the Communists' intentions as we drove along the Wall and saw the bricked-in windows of the buildings, the searchlights, the Communist guards in their perches along the wall, and the many memorials to those who were killed in attempts to escape. If there were any doubts in one's mind about the real meaning of the Cold War and its seriousness, such a tour quickly dispels them.

University education in Berlin is relatively young by European standards, the University of Berlin having been founded in 1808 through the efforts of Wilhelm von Humboldt, then Minister of Education in the Prussian government of Frederick Wilhelm III. The University was housed in the former palace of Prince Henry on the street known as *Unter den Linden*. The Royal Charite Hospital, which dates from an outbreak of the plague in 1710, became the main teaching hospital for the Berlin University. It was here that Rudolph Virchow founded his Pathological Institute in 1856 and promulgated his theory of "cellular pathology," one of the foundations for modern scientific medicine. Professor Thompson, in his book of 1908 about medical travels in Europe (cited at the beginning of Part I of this article) enthusiastically described the numerous post-graduate courses available to the physicians who visited Berlin. At that time Berlin had an Anglo-American Medical Association which had been organized in 1903 to assist visiting physicians with ther arrangements for post-graduate courses. Unlike the similar society in Vienna, the Berlin medical association apparently did not survive the World Wars. Following the Second World War both the Berlin University proper and the Charite Hospital were located in the Russian Zone and it was soon apparent that the old Berlin University (renamed the *Humboldt Universitat*) was under Communist domination. Thus in 1948 the *Freie Universitat Berlin* (Free University of Berlin) was founded in West Berlin with the main campus being in the American occupation zone in the district of Dahlem. The *Stadtischen Krankenhaus Westend* (Westend City Hospital) in the Charlottenburg district of West Berlin became the main teaching hospital for the new Free University, while the preclinical institutes (departments) have been located on the Dahlem campus of the University.

The University Pathological Institute is located at the Westend Hospital and its director is Prof. Dr. Wilhelm Masshoff. I was anxious to meet him because we have had one case of a peculiar type of mesenteric adenitis (clinically simulating acute appendicitis) which he had first described in 1953 when he was still at Tubingen and which he later found to be due to *Pasterurella pseudotuberculosis* (this condition is known in Germany as "Masshoff's lymphadenitis").

I was fortunate to be able to spend a day at the Pathological Institute of the *Stadtischen Krankenhaus Moadbit,* the City Hospital for the district of Moabit, where a former civilian pathologist at the U. S. Army Hospital at

Landstuhl is now working. The hospital itself was founded in 1873 and has some 1000 beds with an additional 200 beds now being added. Most of the work appears to be in general medicine and surgery with only a small obstetrical and pediatric unit. The hospital does have a Roentgen Institute with facilities for radiotherapy. The Pathological Institute for the Hospital is housed in a separate three-story brick building, which is old but in a very good state of repair and which is well equipped for gross and histopathology studies. At present the building is being temporarily shared with the Berlin police medical examiner whose building was located in East Berlin and had to be abandoned after the Wall was erected. The chief of the Pathological Institute is Prof. Dr. Karlferdinand Kloos, who holds a teaching appointment with the Medical Faculty of the Free University. He is assisted by one assistant pathologist and some five or six interns and residents in pathology. The main work-load for the Institute consists of some 1000 autopsies per year. As seems to be the custom in European hospitals, the autopsies are done between eight and ten o'clock in the morning (7 were done the morning I was there). Following this the Professor reviews the gross material from each case and dictates his gross diagnoses. With the exception of an occasional frozen section, very little histological study is done; the prosector dictates a more detailed description the same day and the case is usually completed by the following day. The pathologists have available practically no clinical information prior to starting their examinations, but the clinicians do come between ten o'clock and noon to review the findings with the pathologists. In the afternoons the surgical pathology specimens are examined grossly and microscopically by the Professor and his Assistant. A very well-equipped histopathology laboratory is available and the surgical specimens are processed in much the same way as in most American pathology laboratories. As is true in most of the Pathology Departments which I have visited in Europe, the clinical laboratories are run by the various clinical services. In addition to the routine work, Prof. Kloos is actively engaged in some interesting studies of the placenta from the standpoint of gross and microscopic pathology, fibinolysin activity and gas transport.

I learned from a former associate that someone in the Physiology Institute of the Free University had formerly worked in Chapel Hill, so arrangements were made for me to visit Prof. Ullrich at the Institute the following morning. I arrived at the appointed time to find a new building with many workmen still around and no obvious signs of habitation. Fortunately I stepped across the street to the Dahlem Museum and telephoned Prof. Ullrich, who said that he was in the new building and would come right over to meet me. I had somewhat expected an elderly professor and was pleasantly surprised when a young, friendly man in a white coat walked up and introduced himself as "Karl Ullrich." He told me that he had worked for nine months in Durham and in Chapel Hill with Dr. Carl Gottschalk's group and that Dr. William Lassiter from Chapel Hill was coming to Berlin in August to work with him for a year. He further explained that the Physiology Institute is somewhat unique for Germany in having two chairs of physiology. Dr. Ullrich holds one of the professorships while the other chair is held by Prof. Dr. Otto Gauer, whose main research interest is in blood volume studies. Following our introduction, he took me on a tour of the new buildings. The new building is across from the Dahlem Museum and adjacent to a large new building for the Institute for Inorganic Chemistry. The building is almost a block long and some four stories high. The Physiology Institute is at one end and the Physiological

Chemistry Institute is at the other; these are separated in the middle by several auditoriums for joint use. The first floor of the Physiology Institute has multiple small teaching laboratories where small groups of students meet one day a week with three instructors for a full day of experimentation. Since the medical school classes have about 200 students this allows for more individual contact between the students and instructors. The upper floors of the building are taken up with offices and research laboratories. The latter are well-designed and included small animal operating rooms and X-ray facilities. One somewhat unique feature is a suite of rooms with bathroom and kitchen facilities to be used for experimental studies with human subjects as well as for lodging for visiting scientists. When we arrived on the top floor, Prof. Ullrich showed me through his laboratories, which are the only ones yet occupied. He has several spacious and well-equipped rooms where he is carrying on some fascinating work in renal physiology using micropuncture techniques to study tubular function in experimental animals.

While in Berlin we enjoyed spending an evening with Ruth and Leonard Woodall (class of 1956, UNC Medical School). Leonard has had a busy two years as chief of the obstetrical and gynecological service of the U. S. Army Hospital in Berlin. They will also be returning to North Carolina in June of this year.

Austria

Austria, which before the First World War was an empire of some 70 million persons, is now a small nation of some 9 million persons situated between East and West in the current Cold War struggle. Although neutral in the current struggle (and one of the countries where leaves of American servicemen are stamped "civilian clothing is mandatory"), the Austrians are quite friendly to Americans and one quickly senses the relief that the Austrian people feel that they did not get caught in the grip of the closing Iron Curtain. Although Austria is poor by the standards of the Hapsburg days, its pride in its past and its faith in the future is demonstrated by the reconstruction of the many famous landmarks in Vienna which suffered so much damage during the closing days of the war in Europe. Perhaps no single monument demonstrates this better than the Vienna State Opera House, which was originally opened in 1869 and which burned on the night of March 12, 1945, during the Nazis' retreat from Vienna. The rebuilt opera house was opened with a performance of Beethoven's "Fidelio" on November 5, 1955, less than two weeks after the final occupation troops had left Austrian soil. We were delighted to have the opportunity to attend the opera while in Vienna and were thrilled with the magnificent opera house, the enthusiastic audience and the marvelous music and production. Even more than the fabled Danube, the Opera now seems to be the symbol of Vienna's past and future.

The medical schools in Austria are organized similarly to those in Germany. There are three Austrian medical schools, the youngest being those at Graz (founded in 1863) and at Innsbruck (founded in 1669). The University of Vienna was founded in 1365 and now claims to be the oldest German university (since the University of Prague, founded in 1348, is no longer considered a German university). Records of the Medical Faculty at the University of Vienna extend back to prior to 1400 so that there has been medical teaching at the University for almost 600 years. The large and well-known *Allgemeines Krankenhaus* (General Hospital), founded at the end of the 18th century by

Emperor Joseph II, serves as the main teaching hospital for the Medical Faculty

Medical sightseeing and study by English-speaking physicians in Vienna is facilitated by a rather unique and extremely valuable organization known as the American Medical Society of Vienna. The society had its origin in 1879 when a group of American physicians attending post-graduate courses in ophthalmology founded the "Austro-American Medical Society." This was expanded during the years to provide numerous post-graduate courses in English by members of the Medical Faculty of the University of Vienna. With the exception of a lapse during the First World War, it is estimated that over 32,000 English-speaking physicians attended the University of Vienna courses sponsored by the American Medical Society during the years from 1879 until 1939. The medical association was closed in 1939 by the Nazi government which had annexed Austria. With the help of alumni of the society and the U. S. Embassy in Vienna, the American Medical Society of Vienna was re-

Fig. 5. Frau Engel in front of the entrance to the American Medical Society of Vienna.

opened in June of 1953 and in the past several years has registered more than 1000 physicians a year for post-graduate courses in Vienna. Many of these physicians, like myself, are stationed in Europe with one of the military services and come for short courses, while others are English-speaking physicians from the United States and other countries who come for longer courses. Although specific seminars and courses are listed in the Registry of Post-Graduate Courses published by the Society, this is only a guide and all the courses are practical and are tailor-made for the individual physician on the basis of his interests and the time available. The two persons who are primarily responsible for the success of the Society in providing services to the visiting physicians are Dr. M. Arthur Kline, who is Executive Secretary of the Society (and also serves as physician to the American Embassy in Vienna), and his able secretary, Frau Engel (Fig. 5). Having lived in Vienna most of her life and having worked with the Society since the 1920's, Frau Engel has the solution for all of the many problems of the visiting doctors and has come to be known as the "Angel of the American Doctors in Vienna" (Engel is the German for "angel"). She had maternal concern for all of our needs during our visit but seemed disappointed that we didn't bring our children so she could be a "grandmother" for them.

Because of my interest in both medical history and pathology, I had requested courses in both of these subjects during our brief visit to Vienna in January of 1963. Our first visit was with Frau Professor Erna Lesky at the Institute for Medical History of the University. The Institute (along with the Institute of Pharmacology) is housed in a building known as the Josephinum. It was so named for Emperor Joseph II who had the building erected in the late 18th century to house the Academy for Military Medicine and Surgery which he had founded. Although the building is beautiful and spacious, it suffers from lack of support for the heavy book collections and museums and is now in the process of renovation. Frau Prof. Lesky, who is quiet-spoken but very enthusiastic about the Institute, took delight in our interest in Viennese medical history and in the Institute. Following a brief review of some of the highlights of medical history in Vienna, she took us on a tour of the building. The Institute has an excellent library, which I understand had its origin in that of the Academy (which no longer exists) and in the library of Prof. Max Neuberger, the former Professor of Medical History. The other collection of interest in the Institute is the museum of wax models of anatomical dissections. These were made in Italy over a hundred years ago and are truly works of art.

I had requested several hours of review of gynecological histopathology and was fortunate to be assigned to Dr. J. H. Holzner, a relatively young pathologist who was trained in Vienna and had spent a year at Mt. Sinai Hospital in New York in Dr. Hans Popper's department. Dr. Holzner is now in charge of the pathology laboratory for the *Frauen Klinik* (the two university obstetrical and gynecological hospitals). I spent several hours with Dr. Holzner in reviewing some of his current cases of interest and several selected topics in gynecological histopathology. Later he took me on a tour of the University Pathological Institute, which is in a separate building in the same block as the main portion of the *Allgemeines Krankenhaus*. I was interested in seeing that the large museum of gross pathology in the Institute still contained many of the specimens of Karl Rokitansky (1804-1878), who was the most famous of the Viennese pathologists. The present Chief of the Institute is Prof. Chiari, who is an active, grey-haired gentleman who kindly received me

and insisted that I stand beside him during the gross demonstrations held each morning in order that I might see as much as possible. As in Berlin, the emphasis is on gross pathology as far as the autopsies are concerned, but the surgical pathology is performed much as it is in America. While at the Institute I also enjoyed seeing some of the work being done by Dr. Holzner in his histochemistry laboratory where he is following in the footsteps of Eppinger of Vienna and of Hans Popper in studying liver disease.

One afternoon I visited with Dr. Deutsch, who is well known for his studies in blood coagulation. His laboratories are located on the top floor of the 1st University Medical Clinic building. In addition to his work as a hematologist, he is in charge of the clinical laboratories for the Medical Clinic. Because of my previous work with Dr. Brinkhous' group I was most interested in Dr. Deutsch's new assay for anti-hemophilic factor.

The final afternoon we were fortunate to be able to take the bus tour through the old wine-growing villages north of Vienna, along the Danube and up to the top of the Kahlenberg where one can get a magnificent view of the city and the Danube below. Following this we had a delightful Viennese dinner and then had time for another visit to the art museum before catching our train for Frankfurt.

France

Because of limited time in Paris and in France and because of my relative ignorance of French, my impressions of medical France were rather limited and were confined to external glimpses of buildings and landmarks of medical interest.

France has 24 medical schools, the best known to most Americans being those at the Universities of Strasbourg and Paris. Even older than the University of Paris is the University of Montpellier; both of these have been well-known medical schools from the early Middle-Ages to the present time. The only French medical school which I have had the opportunity to visit is that in Paris, which is now housed in a modern building in the center of the university area on the "Left Bank" of the Seine.

During a walking tour of the university section of Paris it was a thrill to pass the Neckar Hospital where Laennec (1781-1826) had discovered the stethoscope and had made his many contributions to the clinical-pathological knowledge of diseases of the chest. It was also of interest to see the Pasteur Institute, which is composed of a number of old, but well-kept buildings in a two-block area (Fig. 6). My immediate reaction in seeing the Pasteur Institute was much the same as I had experienced when I first saw the Rockefeller Institute in New York some ten years ago—one of disappointment that the buildings weren't more massive and impressive. Yet a few minutes reflection made me realize once again that it is not the buildings or equipment—necessary as they are for modern research—that make an institution or university famous, but the men and the work they do.

England and Scotland

Because of the friendly reception we received and the lack of any language barrier, it was possible to obtain a better view of English and Scottish medicine than of any other. The British Medical Association, through its International Medical Advisory Bureau in London, offers all types of assistance to visiting physicians. The Medical Director of the Bureau, Dr. R. A. Pallister, and his

Fig. 6. Bust of Louis Pasteur in front of the Pasteur Institute, Paris.

staff can assist not only in arranging visits to hospitals, clinics, and laboratories, but as well can assist with problems of travel, lodging, and so forth. Much of what I was able to do in London and Edinburgh was arranged through Dr. Pallister.

The other persons who were most hospitable during our visit were Dr. and Mrs. Isley Ingram. They had spent the year 1960-1961 in Chapel Hill and have

now returned to London where Dr. Ingram is a hematologist working in the Louis Jenner Laboratory of St. Thomas' Hospital. We spent our first weekend in England with the Ingrams in their beautiful home at Esher, a suburb of London. During our visit with them we had a personal experience with Britain's socialized medical system when our 6-year-old daughter fell from a bicycle and suffered a deep laceration of her forehead. Mrs. Ingram drove us in to St. Thomas' where Kathy had X-rays and sutures while her mother was given a shot of brandy and then tea by the nurses who quickly sensed that the mother was paler than the injured child! Kathy had her stitches removed prior to our departure from England and had an uneventful recovery. Even though we were foreigners our medical care for this accident was completely free (yet the more than two English pounds "embarkation tax" which was collected at the airport upon our departure somewhat balanced the account).

London itself has twelve medical schools, which together constitute the Faculty of Medicine of the University of London. The oldest medical school is at the St. Thomas' Hospital and was founded in the thirteenth century. The hospital is located directly across the Thames River from the Houses of Parliament and "Big Ben." One wing of the hospital was destroyed by a bomb near the end of the war and the present buildings are soon to be torn down in stages and replaced by a new and modern plant. St. Thomas' is known not only for its medical school but as well for its nursing school, which was founded by Florence Nightingale.

The St. Bartholomew's Hospital in London claims to be the oldest hospital in the world. According to legend, the hospital and the adjacent Church of St. Bartholomew the Great were founded in 1123 by Rohere, a cleric in the court of King Henry I, following a vision of St. Bartholomew during a pilgrimage to Rome. The church and hospital are situated at what was then the gates of the city on the great plain of Smithfield, where all the public spectacles were held in those times. A beautiful, but simple and rustic church now stands across the street from the present hospital at the site of the original church founded by Rohere. Although there have been many later additions to the church, portions of it date back to the thirteenth century. By contrast, the St. Bartholomew's Hospital Medical College, founded in 1662, is now located some two blocks from the hospital in modern post-war buildings in a campus-like setting.

The Guy's Hospital, which was founded in 1725 and whose medical school was opened in 1769, is located adjacent to the London Bridge and just across the Thames River from the Tower of London. In addition to the older portions, the hospital now has a large modern surgical wing which resembles many of the new VA Hospitals in the United States (Fig. 7). While at Guy's Hospital I had an interesting visit with Dr. G. Payling Wright, the Professor of Pathology, and had the opportunity to visit the pathology museum where are preserved the specimens described by Richard Bright (1789-1858) and Thomas Hodgkin (1798-1866) in their classic descriptions of the diseases which bear their names.

Through the assistance of Dr. Pallister, I was able to visit both the Royal College of Physicians of London and the Royal College of Surgeons of England. The former is located in an old building just off Trafalgar Square, but is moving in a year or two to new and larger facilities in Regent's Park. The most interesting part of the Royal College of Physicians is the library which now contains over 40,000 books on medical and related subjects. The collec-

Fig. 7. New surgical wing of Guy's Hospital, London.

tion was originally based on the library of Thomas Linacre, who founded the College in 1518, and included the library of William Harvey. Many books from these two collections were destroyed in the London Fire of 1666, but many other notable collections and individual volumes have been added in subsequent years to make up the present collection, which is of great historical value.

In contrast to the rather sedate Royal College of Physicians, the Royal College of Surgeons is a beehive of activity since it serves as a center of postgraduate instruction for physicians from all over the Commonwealth who are studying for their qualifying examinations in surgery. It has an active pathology department which appears to have both a teaching and service function. Dr. Proger of the Pathology Department gave me a tour of the department and the pathological museum. Although designed primarily for practical study purposes, the museum contains items of historical interest such as the skull from which Sir James Paget (1814-1899) described osteitis deformans in 1877. The other famous collection which the College has is the museum of the surgeon and anatomist John Hunter (1728-1793). The College building and the Hunterian Museum suffered direct bomb damage during the war, but much of the museum was saved. A new wing of the College building specifically designed for the Museum has just been completed and moving of the collection to it was in progress during my visit. Through the kindness of Miss Dobson, the Curator of the Hunterian Museum, I was able to view some of the beautiful and well-preserved specimens illustrating the nervous system and embryology which Hunter had painstakingly prepared some 200 years ago.

Another building of medical interest in London is the Wellcome Building, which houses the offices of the Burroughs Wellcome & Company. The entire profits from this pharmaceutical company now go to the Wellcome

Foundation for advancement of research in medical and allied sciences. In addition to the company offices the building contains the Wellcome Museum of Medical Science, the Wellcome Museum of Medical History, and the Wellcome Library of Medical History. The former is open to the public but is so well done that it is used by many physicians studying for their advanced degrees or certificates. The British seem to have a great talent in the field of medical museums and this was one of the best examples I have seen. The primary subject covered by the museum was that of tropical diseases with an alcove devoted to each of the diseases. It was so designed that one could have a quick review or spend a good deal of time using the reference materials in each alcove. The Wellcome Library of Medical History was in the process of renovation and repainting during my visit, but I was able to walk through and get some idea of the extensive collection of works on medical history. The Medical History Museum has a number of interesting exhibits relating to medical history. The current exhibit at the time of my visit was on the development of diagnostic instruments in medicine and was extremely well done.

In addition to visiting London, I was able to visit three of the other university and medical centers in England and Scotland—Oxford, Cambridge, and Edinburgh. Oxford is a relatively large city and has the main factories of the Morris Motor Company located on the outskirts. The center of town, however, is dominated by the numerous university buildings. Dr. Ingram drove me up to Oxford, where our first visit was to the Sir William Dunn School of Pathology, which is located at the edge of the University campus in a relatively new brick building. Although we did not have the opportunity to meet Sir Howard Florey, the Professor of Pathology, we had an interesting visit with Dr. J. L. Gowans, who is doing some fascinating work on lymphocytes. Later we walked through the Radcliffe Infirmary, where Dr. Robb-Smith is chief of pathology and where Drs. Biggs and MacFarlane have done most of their well-known work in blood coagulation.

The following day I took the train from London to Cambridge to spend the day there. Cambridge is in a rather isolated area about 55 miles north of London. It is a much smaller town than Oxford and reminded me a great deal of Chapel Hill in that the town and the University are so thoroughly amalgamated. Because I was considering spending a year in England, I had an appointment to see Dr. R. R. A. Coombs in the Pathology Department. Dr. Coombs, who is a physician working in the field of immunology, is best known for the anti-globulin test (the so-called "Coombs test") which he described along with Mourant and Race in 1945 and which is now used in blood banks throughout the world. I was pleasantly surprised to find him to be very young in appearance and extremely friendly. His laboratory is located on the top floor of the University Pathology Department building. In order to get up to his laboratories one has to go up a circular iron staircase similar to those found in a ship or lighthouse. Dr. Coombs states that he prefers this location since it gives a quiet atmosphere with a minimum of interruptions. Much of his work now is in the field of the immunological identification of cells in tissue cultures. In view of a number of cases of sudden unexplained death in infancy (the so-called "crib deaths") which we had been seeing, I was very interested in other recent work in which he had collaborated suggesting the possibility that at least some of these cases may be due to hypersensitivity to cow's milk in infancy. Although this hypothesis is by no means proven, it is an attractive explanation for some of these baffling deaths.

My final side trip from London was to Edinburgh. I left the London train station just before midnight on the "Night Scotsman," an express sleeper train, and arrived in Edinburgh at 7:30 the next morning. I had the entire day in Edinburgh for sightseeing and visiting, leaving that evening on a similar sleeper for London. I found Edinburgh to be one of the most fascinating and striking cities I have seen in Europe. It is divided in two halves by Princes Street, which runs from east to west. On the north side of Princes Street is the "new town" with its business, shopping and residential areas; while on the south side is the "old town" which contains the University and is dominated by the imposing Edinburgh Castle. As a result of prior arrangements by Dr. Pallister at the BMA office in London, I first met Prof. Eric C. Mekie, who is Curator of the Royal College of Surgeons of Edinburgh and Director of Post-Graduate Medical Studies at the University of Edinburgh. I had a fascinating two hours with Prof. Mekie discussing the history of medicine in Edinburgh and in touring Surgeons' Hall, the home of the Royal College of Surgeons of Edinburgh. Afterwards, I walked a few blocks to the University, which like many European universities has no real campus but has buildings intermixed with those of the surrounding area. The University Faculty of Medicine (founded in 1725) uses the 1000-bed Royal Infirmary as the main teaching hospital. It covers the equivalent of a large city block and is composed of numerous connecting buildings of varying ages. The medical school buildings are located across the street in an area crowded with many university buildings. A new 7-story wing for the medical school had been completed just prior to my visit. Although I had no previous engagement with anyone at the Pathology Department, I was given a friendly reception and was given a tour of the departmental facilities in the new building. Prof. Montgomery, the head of the department, was out-of-town, but I enjoyed meeting Dr. D. L. Gardner, who had recently returned from a year of research in the United States and who is doing work in experimental hypertension. Following my visit to the Medical School and lunch with Dr. Gardner, I had several hours remaining before my train for some sightseeing at the Castle, the Palace of Holyrood (the palace of Mary Queen of Scots and now the official residence of the Queen when she visits Edinburgh), and in the city itself.

Epilogue

Although it may seem from the above comments that I have spent two years only in travel, most of these visits and observations have been made during brief periods of leave from my work at the hospital. Because of the various Cold War crises during my stay in Europe Army personnel have been subject to a curfew and many restrictions on passes and leaves, all of which limit the opportunity to travel at any distance from one's base. Never-the-less, I have been very grateful for the opportunity to make these visits and feel that it has been a valuable educational experience in many ways. To medical students and physicians having the chance to go abroad—whether in one of the military services or on their own—I would strongly recommend taking full advantage of the opportunities to meet and observe their medical colleagues in other lands. As Sir William Osler, the first Professor of Medicine at the Johns Hopkins Medical School, so aptly stated in his essay on "The Student Life":

> ". . . it is not only book knowledge and journal knowledge, but a knowledge of men that is needed. The student will, if possible, see the men in other lands. Travel not only widens the vision and gives certainties in place of vague surmises, but the personal contact with

foreign workers enables him to appreciate better the failings or successes in his own line of work, perhaps to look with more charitable eyes on the work of some brother whose limitations and opportunities have been more restricted than his own. Or, in contact with a mastermind, he may take fire, and the glow of enthusiasm may be the inspiration of his life."

At a time when America is the acknowledged leader in the medical world and when it is often popular to assume therefore that medicine in other lands has little to offer, these further words of Osler (from his address entitled "Chauvinism in Medicine") are also worth consideration:

"There is room, plenty of room, for proper pride of land and birth. What I inveigh against is a cursed spirit of intolerance, conceived in distrust and bred in ignorance, that makes the mental attitude perennially antagonistic, even bitterly antagonistic to everything foreign, that subordinates everywhere the race to the nation, forgetting the higher claims of human brotherhood . . . Personal, first-hand intercourse with men of different lands, when the mind is young and plastic, is the best vaccination against the disease [of nationalism in medicine] . . . Let our young men, particularly those who aspire to teaching positions, go abroad. They can find at home laboratories and hospitals as well equipped as any in the world, but they may find abroad more than they knew they sought—widened sympathies, heightened ideals and something perhaps of a *Weltkultur* which will remain through life as the best protection against the vice of nationalism."

Acknowledgments: To Fraulein Johanna Rojan, medical artist, and PFC Larry Schroeck, medical photographer, both of the Medical Illustration Section, Pathology Service, U. S. Army Hospital, Landstuhl, Germany, I would like to express my appreciation for their assistance with the illustrations for this paper.

I am also grateful to Dr. Charlotte Pommer, formerly civilian pathologist at the U. S. Army Hospital, Landstuhl, for the benefit of her advice and assistance in making possible many of my medical travels in Europe.

Highlights Of Alumni Day

Major L. P. McLendon, Sadie MacBrayer McCain of Woman's College, and four distinguished physicians received Distinguished Service Awards from the U.N.C. School of Medicine on March 22.

Physicians tapped for the awards were: Dr. Andrew Jackson Warren, a pioneer public health worker and long-time member of the Rockefeller Foundation, who attended U.N.C. from 1908-1912; Dr. John Sloan Rhodes of Raleigh, "honored physician and citizen of his community," and president-elect of the N. C. Medical Society; Dr. Hugh A. McAllister of Lumberton, former U.N.C. Medical Alumni Association President whose services to the School "have been marked by a dedication and enthusiasm which have earned the gratitude of her students, alumni, faculty, and friends;" and Dr. Paul F. Whitaker of Kinston, former president of the Medical Foundation, vice-president of the American College of Physicians, and one "who has contributed immeasurably to the development of the Good Health Program of the State of North Carolina."

Shown above are (L to R): Dr. Hugh McAllister, '35, Alumni Fund Chairman; Dr. R. L. Pittman, '08, incoming Alumni President; Dr. Harry Brockmann, '15, outgoing Alumni President; Mr. Paul W. Schenck, Jr., President of the Medical Foundation of N. C., Inc.; and Dr. Tom Thurston, '39, Alumni President-elect.

Shown talking with Dr. W. Reece Berryhill, Dean, are the Distinguished Service Award recipients: (L to R) Mrs. McCain, Major McLendon, Dr. McAllister, Dr. Whitaker, and Dr. Rhodes. Dr. Warren was unable to be present for the presentation.

Major McLendon was cited for his work as a "lawyer, humanitarian and statesmen." He was recognized as chairman of the first Board of Trustees Committee on the Medical School and as an ardent champion of the state's Good Health Program.

Mrs. McCain, dean of students at Woman's College, was praised for her contributions, with her husband, the late Dr. Paul McCain, to the School of Medicine and to the development of Gravely Sanatorium as a part of the U.N.C. Medical Center.

Principal speaker at the Alumni Annual Dinner was Holt McPherson, Editor of the High Point Enterprise, who spoke on "The Challenge and Contributions of the School of Medicine and N. C. Memorial Hospital from the Point of View of the Public."

In elections also held here on Alumni Day, Dr. Tom Thurston of Salisbury was named new president-elect of the U.N.C. Medical Alumni Association. Dr. R. L. Pittman of Fayetteville took office as the Association's new president, succeeding Dr. Harry L. Brockmann of High Point.

Also chosen to posts were: Dr. Isaac Manly of Raleigh, vice-president of the Association; Dr. H. Haynes Baird of Charlotte and Dr. David A. Cooper of Bryn Mawr, Pa., Councillors.

Paul W. Shenck, Jr., of Greensboro was re-elected president of the Medical Foundation of North Carolina, Inc. and Howard Holderness of Greensboro was named vice-president.

Lassiter Named Markle Scholar

Dr. William E. Lassiter, assistant professor of medicine in the University of North Carolina School of Medicine, recently was named a Markle Scholar in Academic Medicine, one of the most outstanding honors that can be given to a young medical scientist.

Dr. Lassiter is one of 25 scientists in this country and Canada to be so honored. He is the ninth member of the U.N.C. medical faculty to receive this coveted award.

The appointment from the John and Mary R. Markle Foundation of New York provides a $30,000 grant to the Medical School here where Dr. Lassiter teaches and engages in research. The sum is given over a five-year period to supplement salary, aid research, and assist in the scientist's development as a teacher and investigator.

Dr. Lassiter, a native of Wilmington, joined the U.N.C. medical faculty in 1958 as a research fellow in medicine. He received his A.B., magna cum laude, with highest honors in physics, from Harvard University, and his M.D., cum laude, from the Harvard Medical School. He is the son of Mr. and Mrs. L. R. Lassiter of Wilmington.

Since 1962, Dr. Lassiter has been an assistant professor of medicine here, specializing in internal medicine. In 1962, he was named an Established Investigator by the American Heart Association.

The eight faculty members who have been selected as Markle Scholars previously are Dr. John B. Graham, professor of pathology; Dr. George D. Penick, associate professor of pathology; Dr. Isaac M. Taylor, associate professor of medicine; Dr. Judson J. Van Wyk, professor of pediatrics; Dr. Franklin Williams, associate professor of medicine and preventive medicine; Dr. Walter Hollander, Jr., associate professor of medicine and director, Clinical Research Unit; Dr. Robert Zeppa, assistant professor of surgery and associate director, Clinical Research Unit; and Dr. William D. Huffines, assistant professor of pathology.

Presenting the Faculty

DR. MORRIS A. LIPTON

Dr. Lipton became an Associate Professor in the Department of Psychiatry in 1959, bringing with him an unusual background of training and experience. He is a native of New York City, where he obtained his undergraduate training at City College. He obtained his Master's and Ph.D. degrees in biochemistry at the University of Wisconsin in 1937 and 1939. Subsequent to this, he held a research and teaching position in physiology at the University of Chicago. In 1948 he graduated from that university with honors in medicine. After obtaining his M.D. degree, he completed his training in psychiatry, following which he combined a faculty position with training in internal medicine. In 1955 he was certified by the American Board of Psychiatry and Neurology (psychiatry) and in 1957 was certified by the American Board of Internal Medicine. He is presently an advanced candidate in the Washington Institute for Psychoanalysis.

Just prior to coming to Chapel Hill, he was director of research at the Veteran's Administration Research Hospital in Chicago. He is author of many papers in the areas of biochemistry, physiology, psychiatry, and internal medicine. He holds a five year Research Career Award from the N.I.H.

Presenting the House Staff

DR. CHARLES F. GILBERT

Dr. Gilbert, a native of Benson, North Carolina, is Chief Resident and Instructor in the Department of Pathology. As an undergraduate, he attended Campbell College and the University of North Carolina where he received an A.B. degree in 1955, majoring in Zoology. He attended the University of North Carolina School of Medicine and received his medical degree in 1959.

During his medical training, he did research in endocrinology with Dr. Charles W. Hooker of the Department of Anatomy. His internship and previous years of residency have been in Pathology at the North Carolina Memorial Hospital. He has engaged in research during his residency and has published and presented several scientific studies on generalized salivary gland virus disease, pneumocystis pneumonia and vascular invasion in lung tumors.

Dr. Gilbert will remain in the medical school during the next year and will have a joint appointment in the Departments of Bacteriology and Pathology. He will enter the Army in July, 1964, and his post-service plans are indefinite. He is married to the former Myra Lee Benson of Benson, N. C., and they have one son and a daughter.

DR. SAMUEL G. JENKINS, JR.

Dr. Jenkins, chief resident in surgery at North Carolina Memorial Hospital, was in the tobacco industry for over a year before he came back to UNC for his pre-medical and medical education.

A native of Tarboro, Dr. Jenkins attended Staunton Military Academy and the University of North Carolina, from which he received the B.S. in Commerce in 1948.

He returned to UNC in 1949 to complete pre-medical requirements and entered the School of Medicine in 1951, receiving his degree in 1955. He was a member of Phi Chi and AOA.

Serving his internship at Memorial Hospital from 1955 to 1956, Dr. Jenkins then left UNC for a two-year tour in the U. S. Navy, where he was in the submarine service.

He took up his residency in surgery in July of 1958 and will complete it this June. Married in 1954 to the former Jaquelin Nash, the Jenkins have four children: Jaquelin, 7; Martha, 6; Samuel III, 4; and Pembroke, 1.